CHILD DEATH & SERIOUS INJURY
REVIEW COMMITTEE

Annual Report 2017–2018

Government
of South Australia

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Letter of Transmission

Hon John Gardner MP
Minister for Education

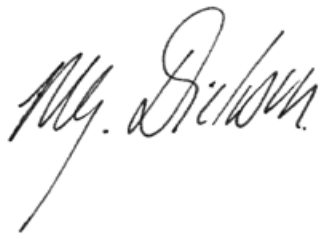
Dear Minister

I submit to you for presentation to Parliament, the 2017-18 Annual Report of the South Australian Child Death and Serious Injury Review Committee which has been prepared pursuant to Part 4 of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*.

This report highlights the Committee's activities in fulfilling its statutory obligations.

In compliance with the *Public Sector Act 2009* and the *Public Finance and Audit Act 1987*, a further report concerning the management of human resources and financial issues of the Committee has been submitted as part of the Annual Report of the Department for Education 2017-18.

Submitted on behalf of the Child Death and Serious Injury Review Committee by:



Meredith Dickson
Chair
Child Death and Serious Injury Review Committee
31 October 2018

Committee Foreword

The Child Death and Serious Injury Review Committee is pleased to present its thirteenth Annual Report to Parliament. This report is provided under Part 4 of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*[1]. The Committee has continued in operation under this Act following the partial repeal of the *Children's Protection Act 1993* on 18 December 2017.

From 17 May 2018, the administration of the provisions governing the Committee were given to the Minister for Education, under the *Administrative Arrangements Act 1994*.

The Committee farewelled its inaugural Chair, Ms Dymphna Eszenyi in June 2018, acknowledging her dedicated work, leadership and direction. As Chair since 2005, Ms Eszenyi established sound governance principles that enabled the Committee to build a strong knowledge-base about child death and serious injury in South Australia. Her leadership has fostered the Committee's commitment to ensuring that systemic barriers to children's safety are addressed in constructive ways that recognise efforts made to provide good services.

The Committee welcomed Ms Meredith Dickson to the role of Chair on 9 July 2018. A barrister with 27 years' experience, Ms Dickson has a keen interest in the ways in which systems and services can impact the lives of children and families.

The Committee's members continue to commit time and expertise to the careful examination of the circumstances and causes of child deaths and serious injuries in South Australia. Members hold expertise (through legal, specialist medical, psychological, health, law enforcement, child development and protection, and disability experience) about the many factors that influence the safety and wellbeing of children. The Committee is aware that few other opportunities exist for the multi-disciplinary review of deaths that it undertakes.

Although challenging at times, the Committee continues to explore and use as many avenues as possible to influence change that achieves good outcomes for children.

[1] *The* Children and Young People (Oversight and Advocacy Bodies) Act 2016 *continued the existence of both the Committee and the Guardian for Children and Young People. It also established two new oversight bodies: the Commissioner for Children and Young People, and the Child Development Council.*

Children die from many different causes. These deaths are a tragedy for the children's families, and the Committee extends its sympathy to the families, friends, communities, and professionals who have cared for those children.

We seek to care for all our children and to keep them safe. The Committee hopes that this Report will assist the efforts of those who work to keep our children safe from harm.

Contents

Figures and Tables

Figures

Tables

Glossary

ABS	Australian Bureau of Statistics
Act	*Children and Young People (Oversight and Advocacy Bodies) Act 2016*
AIHW	Australian Institute of Health and Welfare
ATSI	Aboriginal and Torres Strait Islander
ANZCDR&PG	Australian and New Zealand Child Death Review and Prevention Group
CDSIRC	Child Death and Serious Injury Review Committee
Children	In this report 'children' includes infants, children and young people from birth up to 18 years
DCP	Department for Child Protection
ICD–10	International Classification of Disease (Version 10)
Infant	A child less than one year of age
SAAS	South Australian Ambulance Service
SEIFA	Socio-Economic Indexes for Areas, Index of Relative Socio-economic Disadvantage (IRSD)
SIDS	Sudden Infant Death Syndrome
SUDI	Sudden Unexpected Death in Infancy

Acknowledgements

The Committee wishes to thank the following individuals and organisations for making themselves available to support the Committee's work:

- Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG) representatives attending ANZCDR&PG meetings who share insights gained from their own jurisdictions
- Department for Child Protection for support with: Business Intelligence and Data Warehousing, especially Daniel Moss and Kate Reynolds
- Department of Human Services which continues to provide technical advice and support for the Committee's database, and assistance with records management
- Department for Education for support with: administrative, financial and human resource management
- Kidsafe SA
- National Centre for Health Information Research and Training, Brisbane, especially Ms Sue Walker, Director
- Office of Births, Deaths and Marriages
- SA Health for support from: Data and Reporting Services, especially Aaron Smith; and the Maternal and Perinatal Mortality Committee
- SA Police for their diligent attention to collecting information about child deaths
- State Coroner, Mr Mark Johns, and staff
- Women's and Children's Health Network Records Management team
- Chief Executives and senior officers from the Department for Child Protection, the Department for Education, the Department of Human Services, SA Health and SA Police for contributing to the Committee's understanding of service delivery within their departments.

Committee Members

Chair

Ms Dymphna (Deej) Eszenyi	until 30 June 2018

Members

Dr Mike Ahern	
Ms Angela Davis	
Dr Mark Fuller	
Ms Dianne Gursansky	
Ms Ann-Marie Hayes	
Ms Pam Hemphill	until April 2018
Dr Deepa Jeyaseelan	
Dr Margaret Kyrkou OAM	
Mr Tom Osborn APM	until 30 June 2018
Mr Philip Robinson PSM	
Ms Kerrie Sellen	
Dr Nigel Stewart	until 30 June 2018
Ms Barbara Tiffin	

Executive Summary

In this report, you will find information about the rates and patterns of death in the South Australian child population. The Committee considers these analyses in terms of the opportunities they present to all government and non-government agencies when decisions are being made about policies, practices and services that will impact the lives of children and their families.

The figures presented in the report demonstrate the association between higher numbers of child deaths and greater levels of socioeconomic disadvantage across all categories of death, with the exception of deaths attributed to suicide.

Analysis of the number of sudden unexpected deaths of infants, unsafe sleeping factors and contact with the child protection system, provides further evidence for the provision of safe sleeping programs and safe sleeping places for vulnerable families. The Committee has recommended such programs since 2006.

The 2005-17 rate of death for Aboriginal children who lived in South Australia is 3.94 times higher than the rate for non-Aboriginal children, and the need to address issues about the health and wellbeing of Aboriginal children is highlighted by the number of children dying from illness or disease.

To that end, the Committee welcomes the Government's commitment to appointing a Commissioner for Aboriginal children and young people in South Australia, and anticipates that the incumbent will be a powerful advocate for Aboriginal children.

The Committee continues to improve the statistical analysis of the quantitative information it holds about child deaths and its understanding of statistical analyses conducted by other government departments and agencies, especially where it is being used to make decisions about service delivery to children and their families.

With regard to the in-depth review of deaths and serious injuries to children, this report features recommendations the Committee has made about preventing child deaths due to asthma. Our expert review group concluded that improvements to the recognition and treatment of chronic and unstable asthma in childhood may help to prevent these deaths.

Another expert review group considered the deaths and serious injuries to children caused by the deliberate act of a parent with mental illness. The group made recommendations with regard to the training of workers who support parents with

mental health problems - workers must be trained and supported to take steps to ensure that any potential risks for children are recognised and addressed.

The Committee seeks the support of the Minister for Health and Wellbeing to implement the recommendations arising from these reviews.

The Committee's Suicide Prevention Special Interest Group believes that strategies can be put in place very early in a child's life to help prevent suicide in later years. The group continues to identify and review the suicide deaths of young people, and supports the implementation of prevention strategies that go beyond the amelioration of risks for young people as mental health problems emerge in adolescence.

Since 2017, the Committee has used quarterly website postings of its analyses about the causes of child deaths to strengthen its influence on policy and decision-making, and on community knowledge and understanding. Tracking of these postings shows that they have reached hundreds of people across government in South Australia, in the non-government sector and in child death review teams internationally.

At a national level, the Committee has provided the opportunity for child death review teams to share their knowledge and expertise through its hosting of the annual meeting of the Australian and New Zealand Child Death Review and Prevention Group.

The Committee will continue to improve the ways it analyses and reviews child deaths, and identify how it can use that information to offer contemporary and informed views about issues that impact on the safety and wellbeing of children through its 2018-19 work plan.

Section One

1. Child Deaths South Australia 2005–17

S37 – Functions of the Committee

(1) The functions of the Committee are –

a. to review cases in which children die or suffer serious injury with a view to identifying legislative or administrative means of preventing similar cases of death or serious injury in the future; and

b. to make, and monitor the implementation of, recommendations for avoiding preventable child death or serious injury; and

c. to maintain a database of child deaths and serious injuries and their circumstances and causes.

Children and Young People (Oversight and Advocacy Bodies) Act 2016

1.1. Analysis and review of child deaths

The intent of the Committee is to improve the safety and wellbeing of children in South Australia. It does this by collecting information about the circumstances and causes of all child deaths in South Australia, analysing and reviewing this information, making recommendations to Government, and monitoring the implementation of those recommendations. The Committee reviews specific cases of child death, and from time to time also reviews and analyses information about serious injuries.

The Committee's analysis and review of child deaths and serious injuries, the actions it has taken, including through making and monitoring recommendations, are summarised in this Report.

The Committee has also supported child death review at a national level through its three-year leadership of the Australian and New Zealand Child Death Review and Prevention Group.

1.2. Rates and patterns of death

Opportunities for prevention and intervention to improve the safety and wellbeing of children can be identified through the systemic collection and analysis of information about child deaths.

The *Children and Young People (Oversight and Advocacy Bodies) Act 2016*[2], S37 identifies those deaths as eligible for review if (a) the incident resulting in the child's death or serious injury occurred in the State; or (b) the child was, at the time of the death or serious injury, ordinarily resident in the State. As required by the Act, the Committee maintains a database of child deaths and serious injuries to which it continually adds information that informs its analyses about rates and patterns of child death in South Australia.

Figure 1 shows death rates for all children who died in South Australia between 2005 and 2017, and Figure 2 shows death rates for only those children who were usual residents in South Australia. Over these 13 years, the average yearly population of children aged 0 to 17 was 355 196[3].

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2 https://www.legislation.sa.gov.au/LZ/C/A/CHILDREN%20AND%20YOUNG%20PEOPLE%20(OVERSIGHT%20AND%20ADVOCACY%20BODIES)%20ACT%202016.aspx

[3] For more information on how this number was calculated, see Section Four: Methods

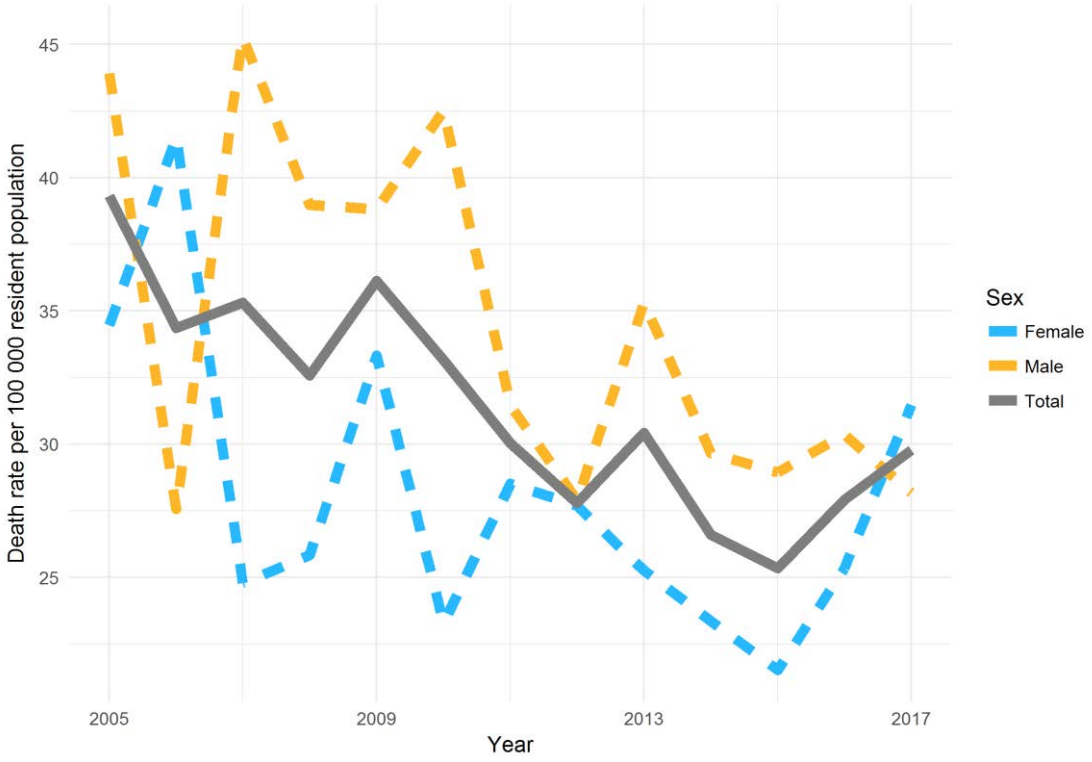

Figure 1: Death rate by year of death and sex for all children, South Australia 2005-2017

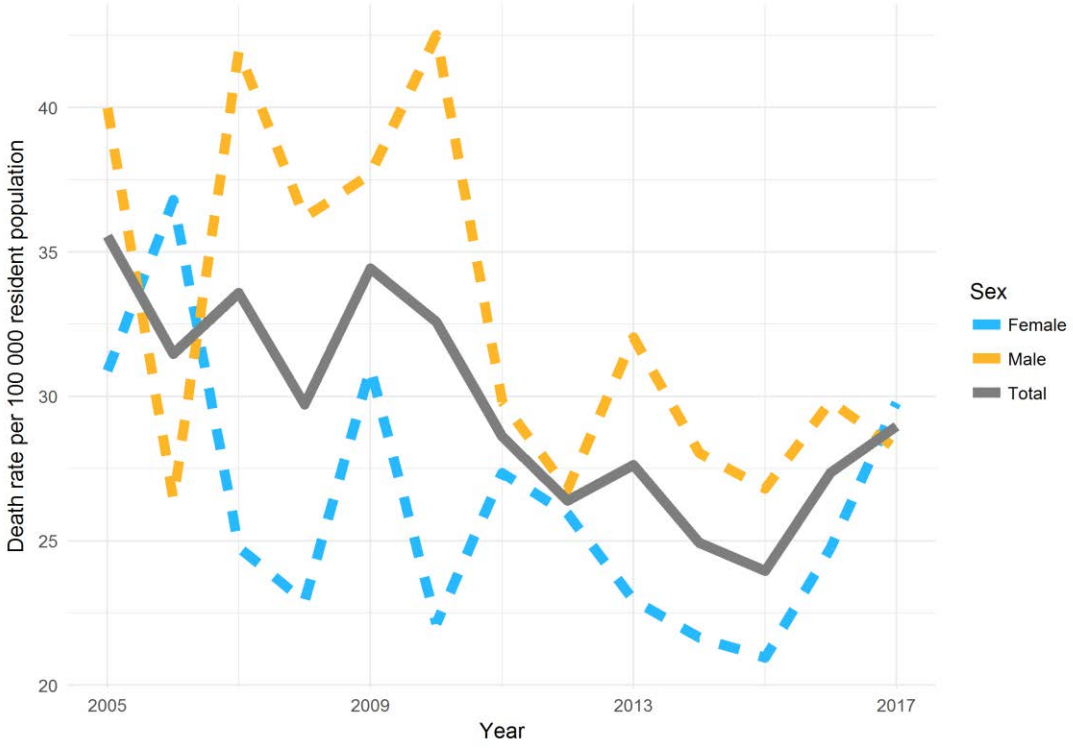

Figure 2: Death rate by year of death and sex for children who were usual residents, South Australia 2005-2017

1.2.1. Death rates by region

Important issues for service planning and delivery are highlighted when death rates and numbers of deaths are mapped against the South Australian Government's twelve administrative regions[4].

The highest death rates are associated with living in the Far North and the Yorke and Mid North regions. In contrast, the greatest numbers of deaths are recorded in the Northern Adelaide and Southern Adelaide regions. Services should be planned and delivered to take into account regions where the rate of death is highest, and regions where the greatest number of deaths occur.

[4] *The full breakdown of deaths, population and rate for each region is in Data table 3.*

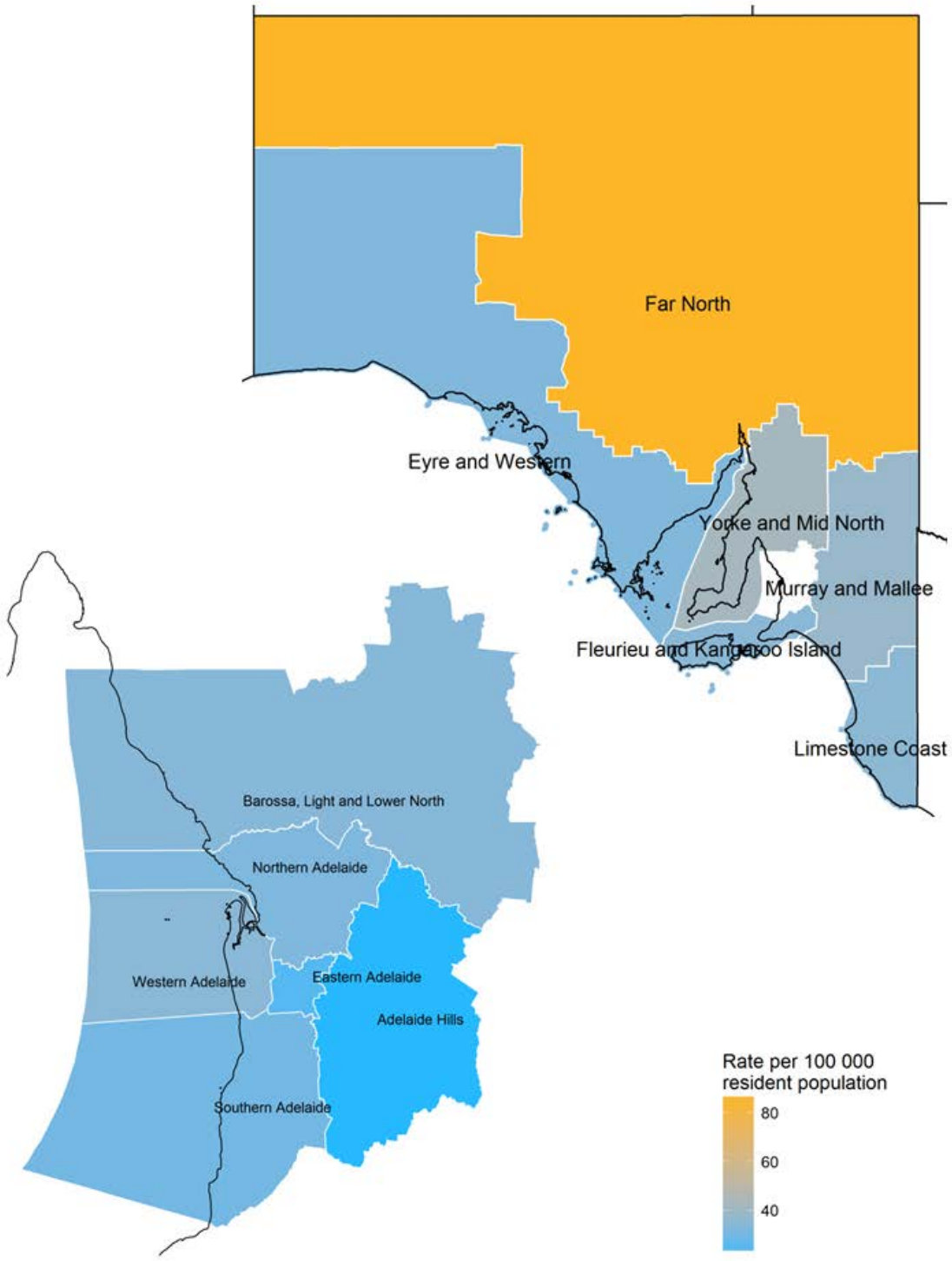

Figure 3: Death rate by region, for children who were usual residents and had a definable geographic region, South Australia 2005-2017

1.2.2. Age and causes of death

Children die from many different causes, broadly categorised as:

- Deaths from illness and disease, including conditions related to prematurity and birth, infections, genetic and other disorders, and cancer.
- Deaths from external causes – or injury-related causes – including deaths attributed to transport crashes, deliberate acts by another person, fire, drowning, suicide and accidents.
- Undetermined causes of death. No apparent cause can be found for these deaths. This category includes Sudden Infant Death Syndrome (SIDS).

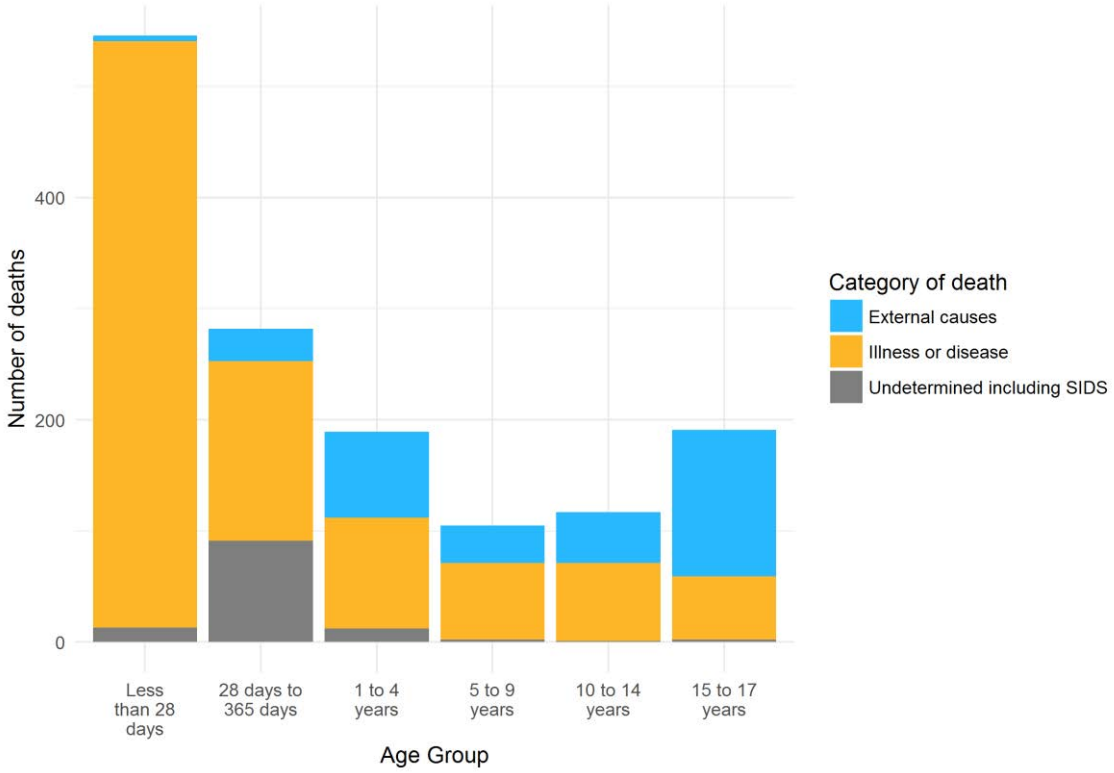

Figure 4: Number of deaths by age group and category of death for all children, South Australia 2005-2017

The leading causes of death for South Australia's children are those causes attributed to illness and disease, especially for very young infants. Older children are more likely to die from external causes, particularly transport crashes and by suicide.

1.2.3. Deaths of non-resident children

Eighty-four of the 1449 children who died in South Australia between 2005 and 2017, were usually resident in another state, territory or country.

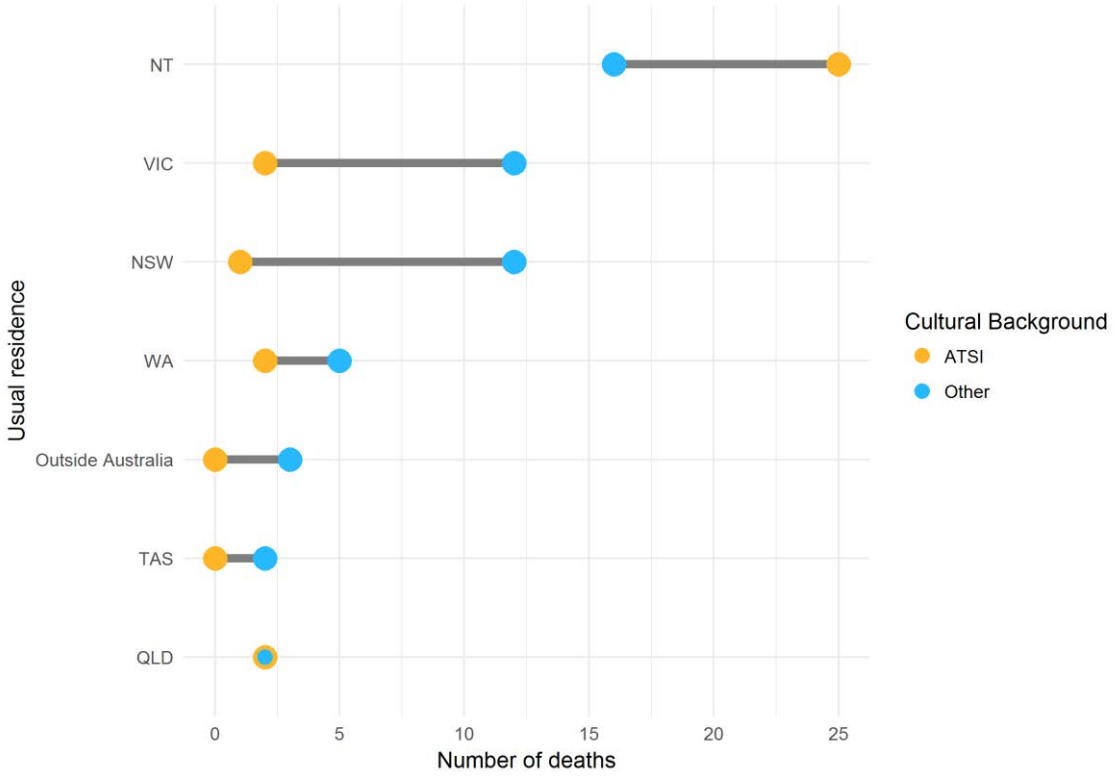

Figure 5: Number of deaths by state, territory or country of residence and cultural background, for children who were not usual residents of South Australia, 2005-2017

The highest number of non-resident children who died in South Australia between 2005 and 2017, were 41 children from the Northern Territory, 25 of whom were Aboriginal and Torres Strait Islander (ATSI) children.

Many of these deaths occurring in South Australia reflect cross-border arrangements where seriously ill children are brought to Adelaide for high level medical care for treatment of complex medical conditions associated with extreme prematurity, infant and childhood illness, and various external causes.

1.2.4. Child death and socioeconomic disadvantage[5]

More children die in areas of South Australia where there are greater levels of socioeconomic disadvantage[6]. The relationship between child deaths and socioeconomic disadvantage, across various categories of death, are shown in the following figures. Deaths of all children who were resident in South Australia between 2005 and 2017, and for whom a cause of death is known, were included in this analysis. The following key points were highlighted by the analysis:

- Between 2005 and 2017, there is a broad pattern of an increasing number of deaths at higher levels of disadvantage, across all categories of death and all age groups.
- There is a consistent pattern of low numbers of deaths in the age range 5 to 14 years, with numbers peaking in the youngest (0-4 years) and oldest (15-17 years) age groups.
- The increase in the number of deaths in those younger and older age groups is greater where levels of socioeconomic disadvantage are higher. There is a particularly high number of deaths in children under one year of age at higher levels of socioeconomic disadvantage.

When considering disadvantage and various categories of death:

- There is a strong association between higher levels of socioeconomic disadvantage and children dying from illness or disease (0-4 age group) and in transport crashes (15-17 age group).
- Deaths caused by fire, drowning, and deaths resulting from the deliberate act of another person, all involved greater numbers of children from areas of higher socioeconomic disadvantage.

  The distribution of deaths in those three categories also highlights the vulnerability of toddler and pre-school aged children; the greatest number of deaths occurred in the 1 to 4 year age group.
- Suicide deaths stand out as they indicate the least evident effect of socioeconomic disadvantage.

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[5] *This chapter was originally published on the Committee's website in April 2018: http://www.cdsirc.sa.gov.au/?p=240*
[6] *For information on how socioeconomic disadvantage is defined and used in this Annual Report see Section 4: Methods*

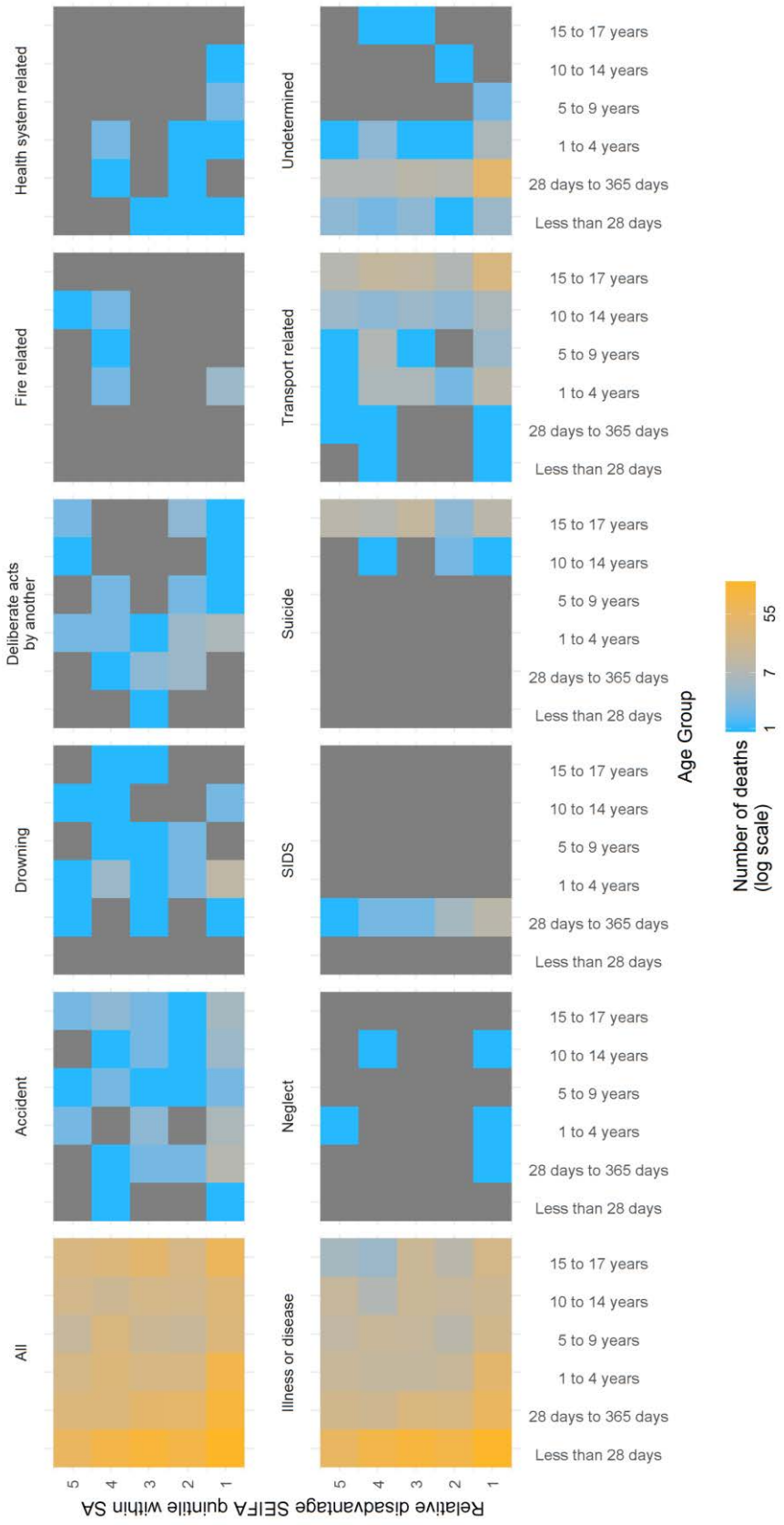

Figure 6: Number of deaths by age group and relative advantage and disadvantage SEIFA quintile, for children who had a definable SEIFA level in South Australia, 2005-2017

1.3. Child deaths and the child protection system

The Committee continues to review deaths of children where a child or their family have had contact with the child protection system, to monitor the implementation of recommendations associated with these reviews, and to analyse the number and causes of deaths.

1.3.1. The number and causes of death for children who had contact with the child protection system

In the thirteen years from 2005 to 2017, 389 of the 1449 children who died (26.85%), or their families, had had contact with the child protection system in the three years prior to their deaths. Of these 389 children, 202 (51.92%) lived in the State's most disadvantaged areas[7].

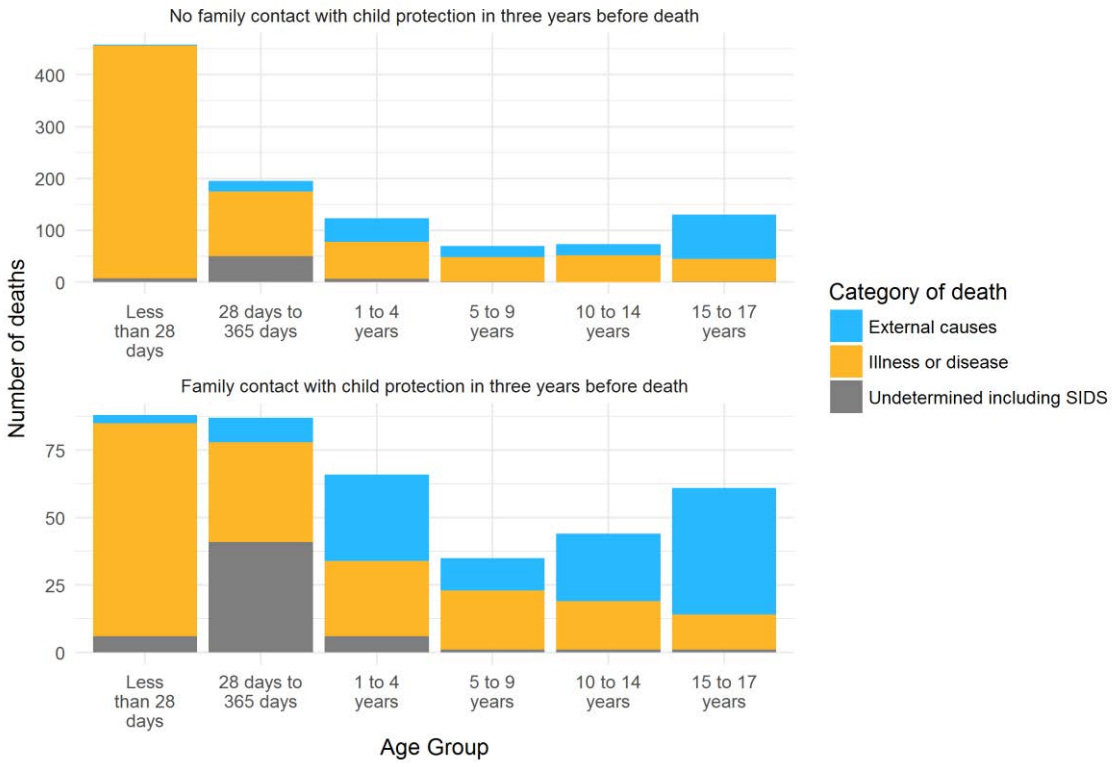

Figure 7: Number of deaths by age group, category of death and child protection contact status for all children, South Australia 2005-2017

[7] *As represented by postcodes within the lowest relative disadvantage SEIFA quintile within South Australia. For more information on how socioeconomic disadvantage is defined and used in this Annual Report see Section 4: Methods*

Notable in Figure 7 are the number of deaths of infants with a family history of contact with child protection aged between 28 days and one year old. In this group, the leading cause of death is attributed to undetermined causes, including SIDS.

1.3.2. Child protection systems, sudden unexpected infant death, and unsafe sleeping

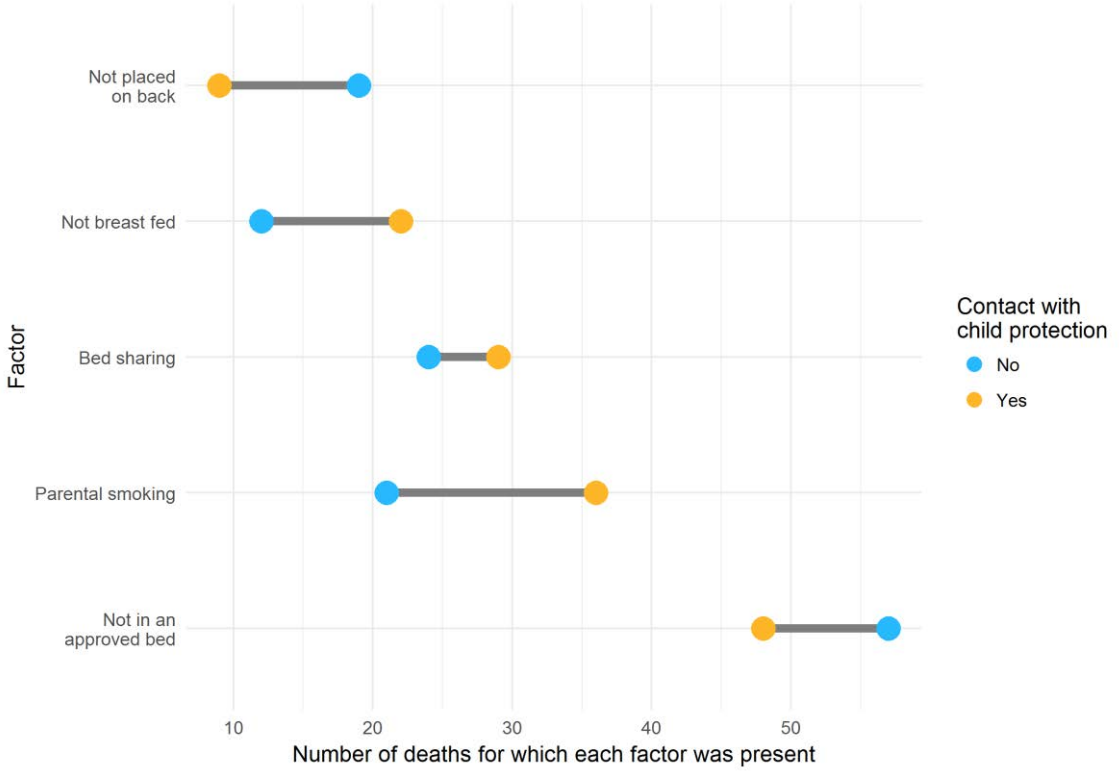

Figure 8: Percentage of deaths involving five unsafe sleeping factors, by each factor and child protection contact status, for children aged less than 12 months whose death was sudden and unexpected and occurred after being placed to sleep, South Australia 2005-2016

Section 1.5.1 of this report examines the circumstances of the 128 sudden unexpected deaths of infants less than one year old which occurred after they were placed to sleep. These deaths occurred in South Australia between 2005 and 2016 inclusive[8]. In 118 of these 128 deaths, there was at least one unsafe sleeping factor present. Of these 118 deaths, 58 infants, or their family (49.15%), had had contact with the child protection system in the three years prior to their death. Figure 8 shows a comparison of the unsafe sleeping factors in the circumstances of these deaths.

[8] *At the time of publishing, the most recent year available that included all SUDI was 2016.*

All infants, regardless of contact with the child protection system, are at greater risk when they are not placed to sleep in an approved bed. Parental smoking, not being breast-fed and bed-sharing are factors occurring more frequently in the circumstances of the deaths of infants whose families had contact with the child protection system.

Prevention measures that could be taken to address the extraordinarily high proportion of deaths in this group of infants include:

- training in the use of the South Australian Safe Infant Sleeping Standards[9] for all workers, including child protection workers, involved in the provision of care to infants
- support for smoking cessation programs in the ante-natal period, along with programs to improve rates of breast-feeding, especially for vulnerable women.

In its 2016-17 Annual Report, the Committee noted the indicators of success for a public health campaign that addressed the disproportionate number of infants from disadvantaged circumstances dying suddenly and unexpectedly[10].

The Committee continues to support the introduction of a safe sleeping program similar to the New Zealand program that focuses on preventing infant 'sleeping deaths' through education about safe sleeping and the provision of portable infant sleeping devices.

1.3.3. Priority areas for change to the child protection system

The Committee is of the view that areas of priority for potential changes to child protection policy and practice continue to be:

- the frequency and management of notifications 'closed no action' and where 'resources prevent investigation'
- the system's response to multiple notifications and its identification of, and response to, neglect
- the system's response to infants at risk/high risk infants, especially at the point of discharge from birthing hospitals, and improving partnerships with both the health system and early childhood non-statutory services

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[9] *http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/child+health/safe+infant+sleeping+standards*

[10] *CDSIRC Annual Report 2016-17 p 30 http://www.cdsirc.sa.gov.au/wp-content/uploads/2017/11/2016-17-CDSIRC-Annual-Report.pdf*

- the provision of services to children under guardianship, including those who are transitioning from guardianship, with a focus on trauma-informed responses
- the development of a strong and responsive practice framework relevant to the varying requirements and contexts of child protection work
- the frequency and quality of supervision for practitioners dealing with complex cases, and for the significant number of practitioners with limited training or experience in child protection work
- recruiting and maintaining expertise in the child protection workforce
- the role and effectiveness of internal oversight committees – Adverse Events, Care Concerns, Risk and Audit
- continuing to improve the interface between the work of child protection practitioners and the Department for Education Child Wellbeing Practitioners.

1.3.4. Monitoring change in South Australia's child protection system

The South Australian child protection system continues to experience significant legislative, organisational and administrative change since the release of the Child Protection Systems Royal Commission Report 'The Life They Deserve' (2016)[11]. The Committee has sought to monitor the impact of these changes in several ways.

Reviewing and monitoring change to child protection policies and practice

In response to recommendations made by the Committee in December 2017, the Department for Child Protection (DCP) confirmed the development of a suite of policy measures designed to improve child protection practices. These policy measures include:

- the development of a Clinical Governance Framework
- the development of a Practice Framework and Practice Standards and a Practice Enquiry Team
- the development of a Supervision Framework and a new regional reporting structure
- the development of a Capabilities Framework

[11] *https://www.agd.sa.gov.au/projects-and-consultations/projects-archive/child-protection-systems-royal-commission*

- review of the Infants at Risk policy
- improved service provision to children under guardianship.

In August 2018, the Committee met with senior executives from DCP with the purpose of clarifying implementation strategies and timeframes underpinning these policy changes, and the ways in which the effectiveness of these measures would be evaluated. In particular, the Committee sought to understand how these measures might address the priority areas for change it had identified.

This meeting provided some clarification and it was clear to the Committee, that two years after the release of the 2016 Royal Commission Report, the achievement of the proposed reforms posed significant challenges for the child protection system. In the Committee's view, changes to policy and practice are just beginning and will take time to implement and be evaluated. The Committee will meet again with DCP in November 2018.

In the interim, the Committee will continue to examine the electronic case management files (C3MS) associated with each child who has had contact with the child protection system, and has died, including the child protection history associated with the parent(s) of that child and/or their siblings. In 28 in-depth reviews into the circumstances and causes of these deaths, the Committee has made recommendations about child protection issues. With some limitations, this reading and review work provides the Committee with a contemporary knowledge of the ways in which child protection is being practised in South Australia.

Based on its reading of files where deaths have occurred since 2016 (ie the 40 deaths of children in 2017), the Committee considers that there remain significant ongoing systemic and practice issues that will need to be improved to ensure quality child protection practice.

Reviewing and monitoring the influence of data analytics on the work of the child protection system

The Committee has identified a number of key agencies whose work has the potential to influence child protection policy and practice. These bodies include the Office of Data Analytics (ODA), the Early Intervention Research Directorate (EIRD), the Australian Centre for Child Protection (ACCP), the University of Adelaide's Better Start Research Group, and the University of SA's Health Economics and Social Policy Group. Each of these groups works with large administrative data sets to identify and provide direction for child protection policy and practice change.

The Committee has met with representatives from each of these agencies/groups to better understand the scope of the work they are undertaking, the ways in which that work might impact on the policies and practices of child protection services in South Australia, and the timeframe within which the impact of these changes can be anticipated. Upon request, feedback has been provided to those agencies about the scope and direction of their work, eg the Committee's commentary regarding EIRD's Prevention and Early Intervention Strategy for Child Abuse and Neglect 2018-2022 was provided in October 2017.

1.3.5. Children under guardianship of the Minister

For the purposes of review, the Committee identifies children who have died, and who have ever been in the care of the State, or in care in another jurisdiction. The Committee has identified 25 children who died between 2005 and 2017 who meet these criteria. The Annual Report 2016-17 summarises a review concerning eleven children with disabilities who were under the guardianship of the Minister at the time of their deaths[12].

In addition, the Committee has identified 24 infants or children who died, where one or both of their parents had, at some stage during their lives, been in State care. Fifteen of the parents of these infants or children have been the subject of two in-depth reviews. This group of parents experienced complex and challenging life circumstances that were further compounded by the loss of a child. In the reviews, the Committee identified service improvements to help mitigate the risk of such loss:

- improved communication between states and territories that would ensure the timely exchange of information, given that these parent(s) can be highly mobile
- recognising and responding to the long-term consequences of trauma, including the provision of therapeutic care for children under guardianship
- transition-from-care plans for all young people under guardianship, and ensuring the timely and appropriate extension of support for these young people up until age 25
- support for young parents who have a history of guardianship that extends into the early years of their child's life

[12] *CDSIRC Annual Report 2016-17 p21 http://www.cdsirc.sa.gov.au/wp-content/uploads/2017/11/2016-17-CDSIRC-Annual-Report.pdf*

- support for grief and loss issues when these parents experience the death of a child.

Further details about these reviews can be found in the Committee's annual reports of 2014-15[13] and 2016-17[14].

The Child Protection Systems Royal Commission Report identified similar issues for children under guardianship, and has provided the child protection system with the impetus to implement legislative and policy reforms.

With regard to cross-border information-sharing, in its December 2017 response to the Committee's recommendations, DCP reported that there would be improvements in its ability to ensure supports were provided to children and young people moving around Australia, and that 'Community Services Ministers had agreed to progress approaches to data and information sharing in 2018'. The Committee reinforces the critical importance of the timeframe for improving cross-border information exchange for the safety of vulnerable children and young people.

The Committee notes that legislative reform (Children and Young People (Safety) Act 2017)[15] now allows DCP to offer assistance to young people who are transitioning from guardianship up to and including the age of 25 years. The Department stated that every child under guardianship would have a case plan, and a transition-from-care plan, before they exited the out-of-home-care system. The Department reported that as of September 2017, 290 of 508 young people aged 15-17 years had a completed and approved case plan. Its report did not indicate by what date it would achieve the goal of care and transition plans for all children and young people under guardianship.

In relation to trauma-informed services, DCP stated that it was 'committed to improving models of care and services to young people in care aged 15 years and over that would better support them to address the impacts of trauma and transition to a successful adult life'. The Department reported that it would work with other service providers to address the complex needs of young parents with a care history, and anticipated that 'post-care' services tailored to the needs of young parents would be

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[13] *CDSIRC Annual Report 2014-15 p 2-5 http://www.cdsirc.sa.gov.au/wp-content/uploads/2017/07/2014-15_cdsirc_annual_report.pdf*

[14] *CDSIRC Annual Report 2016-17 p 15-16 http://www.cdsirc.sa.gov.au/wp-content/uploads/2017/11/2016-17-CDSIRC-Annual-Report.pdf*

[15] *https://www.legislation.sa.gov.au/LZ/C/A/CHILDREN%20AND%20YOUNG%20PEOPLE%20(SAFETY)%20ACT%202017.aspx*

available. The Committee awaits evaluations that will demonstrate the impact these new programs are having on outcomes for children under guardianship.

The Committee will continue to identify and review the life circumstances of this very vulnerable group of infants, children and their parents, and will monitor the potential impact of the legislative and policy changes implemented since the release of the Child Protection Systems Royal Commission Report.

1.4. Deaths of Aboriginal children

1.4.1. The number and causes of Aboriginal child deaths

In the period 2005 to 2017, Aboriginal children constituted only 2.84% of the child population of South Australia, but they accounted for 11.94% of child deaths.

The rate of death for Aboriginal children was 131.89 deaths per 100 000 Aboriginal children over the 2005-17 period. For Aboriginal children whose usual residence was South Australia, the death rate was 107.49 deaths per 100 000 over the same period. This difference in rates reflects children with complex medical conditions who were retrieved from other states for treatment in South Australian hospitals (see Section 1.2.3). The rate of death for non-Aboriginal children was 28.44 deaths per 100 000 non-Aboriginal children.

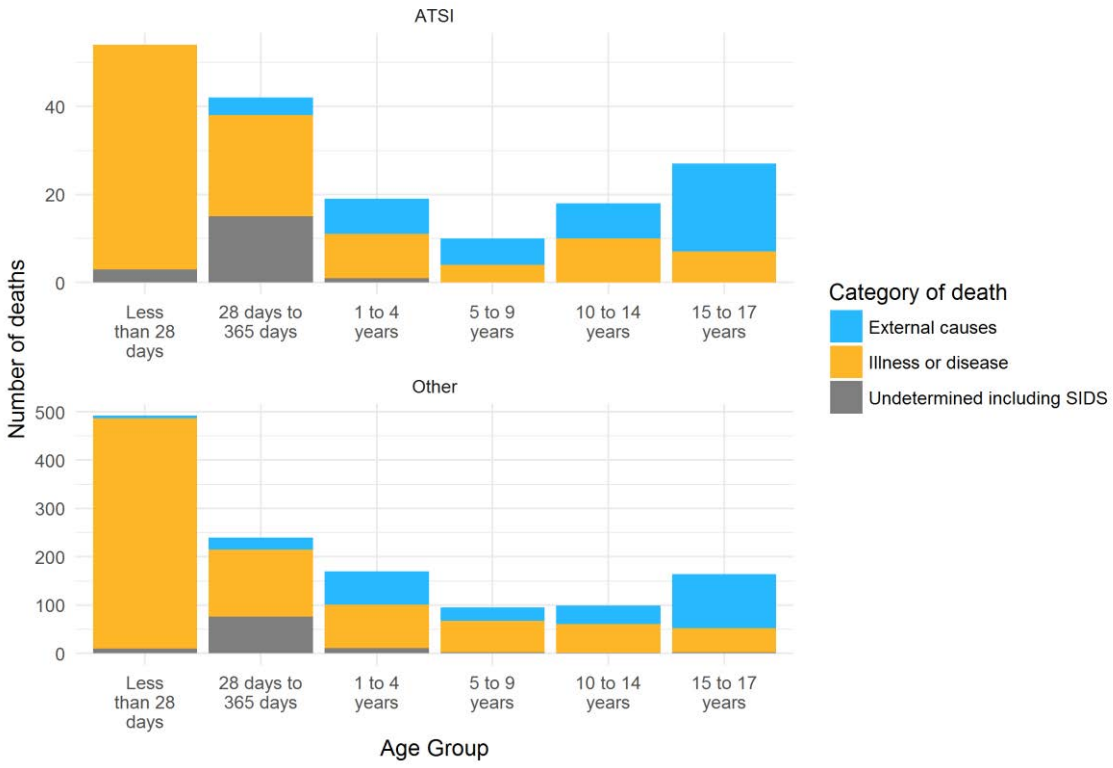

Figure 9: Number of deaths by category of death and cultural background for all children, South Australia 2005-2017

The distribution of Aboriginal child deaths across age groups is similar to the distribution of deaths for non-Aboriginal children, although a greater proportion of Aboriginal children are dying in the first year of life compared to non-Aboriginal children.

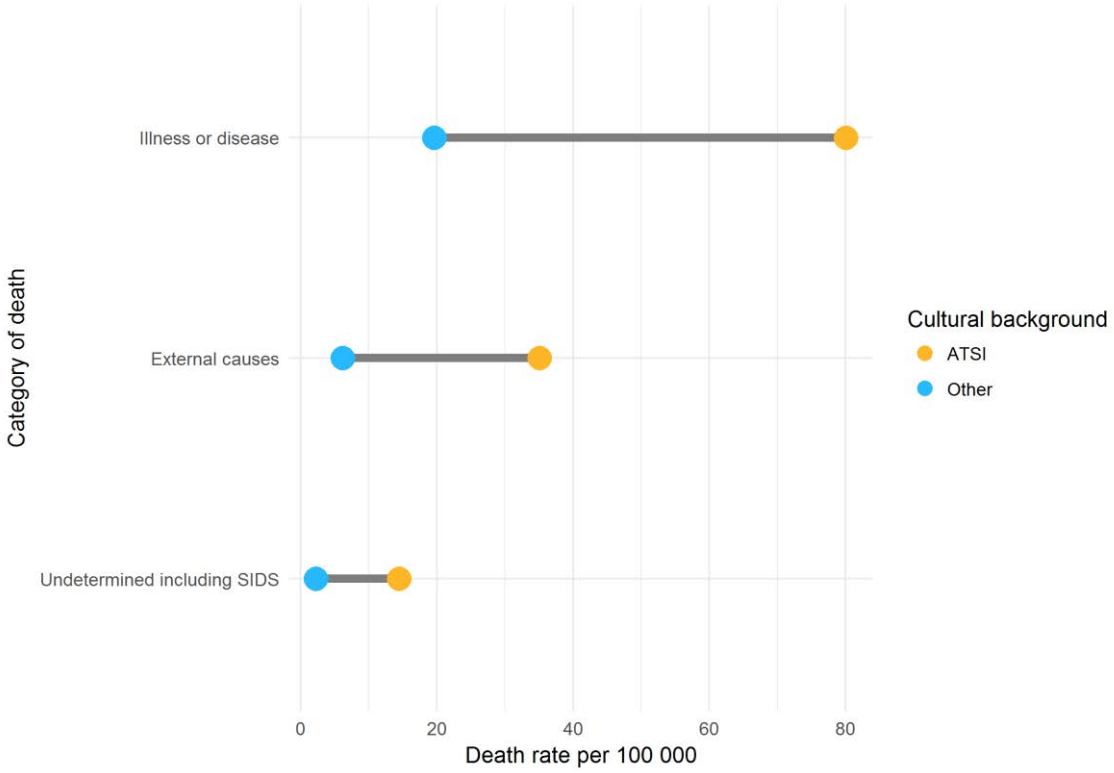

Figure 10: Death rate, by category of death and cultural background for all children, South Australia 2005-2017

Across all three categories of death, the death rate is higher for Aboriginal children, than for non-Aboriginal children. It is particularly noticeable that the death rate due to illness or disease for Aboriginal children is more than four times the rate for non-Aboriginal children. This difference in rates suggests that prevention efforts for Aboriginal children should continue to focus on factors that address the fundamental determinants of health.

1.4.2. Monitoring system improvements for Aboriginal children

The Committee's review in 2016-17[16] illustrated the impact of long-term life stressors and high-risk environments on the lives of two young Aboriginal women.

The Committee's concern about these issues, the disparity between the death rates for Aboriginal and non-Aboriginal children, and the work that it has done previously highlighting the challenges facing Aboriginal children[17], prompted it to strongly support

[16] *CDSIRC Annual Report 2016-17 p 18* http://www.cdsirc.sa.gov.au/wp-content/uploads/2017/11/2016-17-CDSIRC-Annual-Report.pdf
[17] *CDSIRC Annual Report 2014-15 Annual Report: Special Report on Aboriginal Child Deaths p xvii-xxxii* http://www.cdsirc.sa.gov.au/wp-content/uploads/2017/07/2014-15_cdsirc_annual_report.pdf

the call for a Commissioner for Aboriginal Children and Young People in South Australia.

In January 2018, the Committee hosted a meeting between several oversight and advocacy bodies and the Victorian Commissioner for Aboriginal Children[18] who was in South Australia at the request of the Aboriginal Legal Rights Movement. Commissioner Jackomos provided valuable insights into the ways in which a commissioner for Aboriginal children could be a positive and powerful advocate for change. He also outlined the scope of the legislative powers a commissioner needed to be effective in the role.

The South Australian Government is finalising legislation to establish a Commissioner for Aboriginal Children and Young People. The Committee is encouraged by this initiative, but holds concerns about:

- The scope of legislative powers provided to the Commissioner for Aboriginal Children and Young People and the interface between this Commissioner and the (already established) Commissioner for Children and Young People.
- The resources available for the establishment and effective operation of a Commissioner for Aboriginal Children and Young People.

In the review of two young Aboriginal women, the Committee recommended strengthening the Aboriginal Placement Principle in the *Children and Young People (Safety) Bill 2016.* In its December 2017 response to this recommendation, DCP confirmed that the *Children and Young People (Safety) Act 2017*[19] had been strengthened by requiring the connection to be made between Aboriginal children and their families and culture, and also by requiring a partnership approach to decision-making with families. However, it did not address the issue of re-connecting and re-establishing connection where that connection had been disrupted, or the importance of review when a decision that re-connection was not in the best interest of a child, had been made.

In the same review, the Committee recognised that it was not possible for one agency to provide the services needed by Aboriginal children and their families, and recommended an integrated model of service delivery. In response, DCP acknowledged the over-representation of Aboriginal children in the child protection

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[18] *https://ccyp.vic.gov.au/about-the-commission/our-commissioners/#TOC-2*

[19] *https://www.legislation.sa.gov.au/LZ/C/A/CHILDREN%20AND%20YOUNG%20PEOPLE%20(SAFETY)%20ACT%202017.aspx*

system and stated that *'an Aboriginal focus will be put across the entire child protection system'.*

The Department stated its commitment to working with relevant stakeholders to develop and support an integrated and collaborative response to need.

With regard to antenatal supports for young women, DCP stated that it would work in partnership with the Department for Education's Child and Family Assessment and Referral Networks (CFARNs) and the Women's and Children's Health Network (WCHN). The Department also stated that its work would be informed by '*the nation-leading research of the Early Intervention Research Directorate, who have a specific focus on Aboriginal children and families'.* To develop its own understanding of the best ways to effect meaningful change for Aboriginal children and their families, the Committee has attended several meetings with the Aboriginal Community Leadership Reference Group. The Committee will seek the views of this group, about the impact of the proposed changes.

1.5. Deaths of children with disability

Families caring for children with a disability face significant challenges in accessing services and support for their children. Information about the deaths of all children in South Australia is reviewed by the Committee in order to determine whether a child's daily activities had been significantly limited by disability.

During the period 2005 to 2017, 313 of the 1449 children who died in that period (21.6%), were assigned disability status by the Committee[20].

1.5.1. The number and causes of death for children with disability

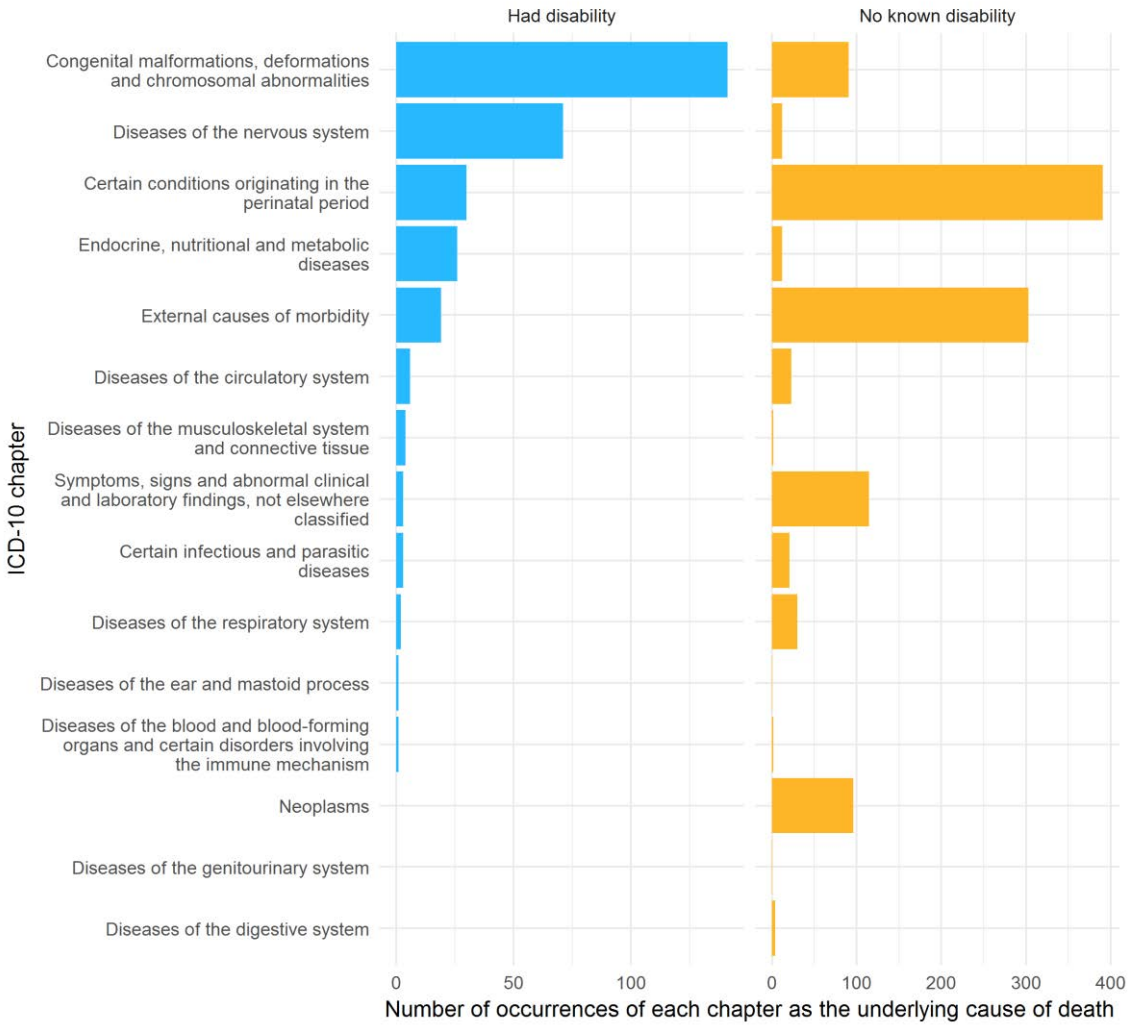

Figure 11: Number of occurrences of ICD-10 underlying cause of death, by disability status, for all children, South Australia, 2005-2017

[20] *See Section 3.6 for the Committee's definition of disability status.*

The causes of death for children whose daily lives were impacted by a disability, when compared with children with no disability:

- are more commonly associated with congenital and chromosomal abnormalities
- more frequently include diseases of the nervous system (this includes cerebral palsy and epilepsy) and diseases of the respiratory system.

Once children aged 1-17 years are identified as having a disability, the Committee assigns one or more disability types. Nearly one-third of these children (31%) have more than one type of disability.

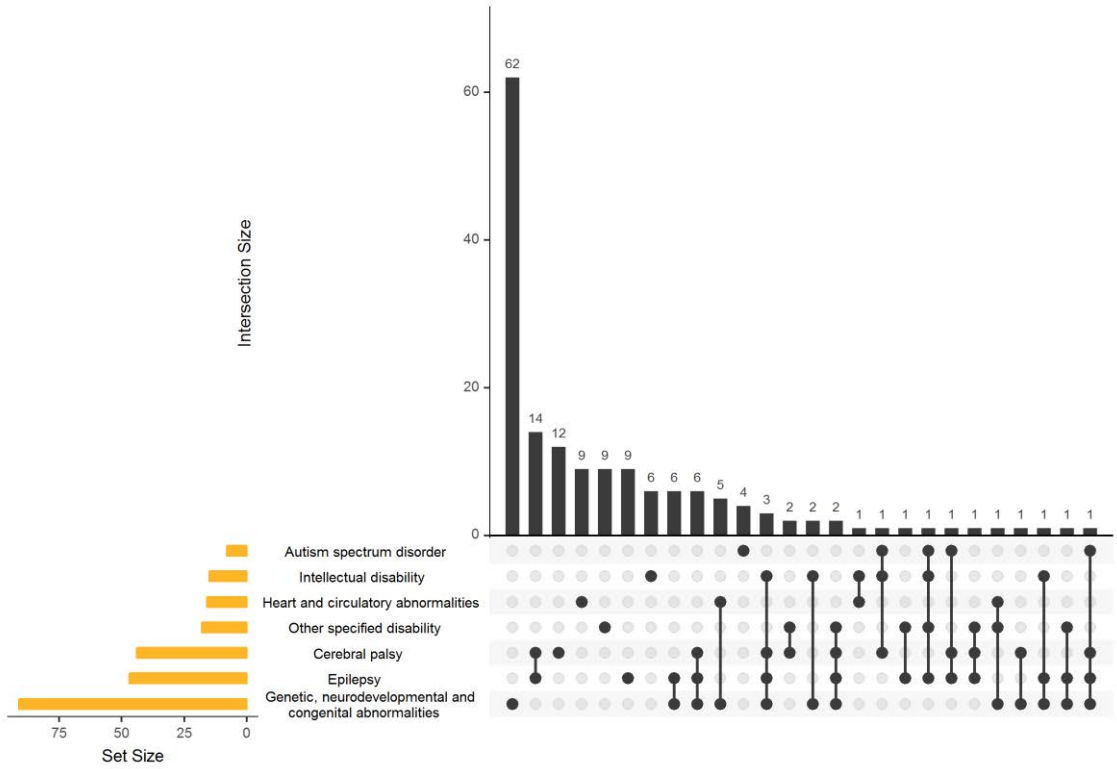

Figure 12: Number of occurrences of disability types, by number of occurrences of each combination of disability types, for children with a disability status aged 1-17 years, South Australia 2005-2017

Figure 12 shows, for example, that of the eight children who died who had been diagnosed with autism spectrum disorder (ASD), half had no other diagnoses. Of the other four: one had been diagnosed with ASD, an intellectual disability and cerebral palsy; one had been diagnosed with ASD, an intellectual disability, epilepsy and another specified disability; one had been diagnosed with ASD, cerebral palsy and epilepsy; and another had been diagnosed with ASD, cerebral palsy, epilepsy and a genetic, neurodevelopmental or congenital abnormality.

In terms of service provision, it is notable that a higher number of children died who had both epilepsy and cerebral palsy (28) compared to the number of deaths of children with epilepsy alone or in conjunction with another disability (19).

1.6. Infant mortality

Of the 1449 children who died in South Australia between 2005 and 2017, 833 (57.49%) were children under one year of age.

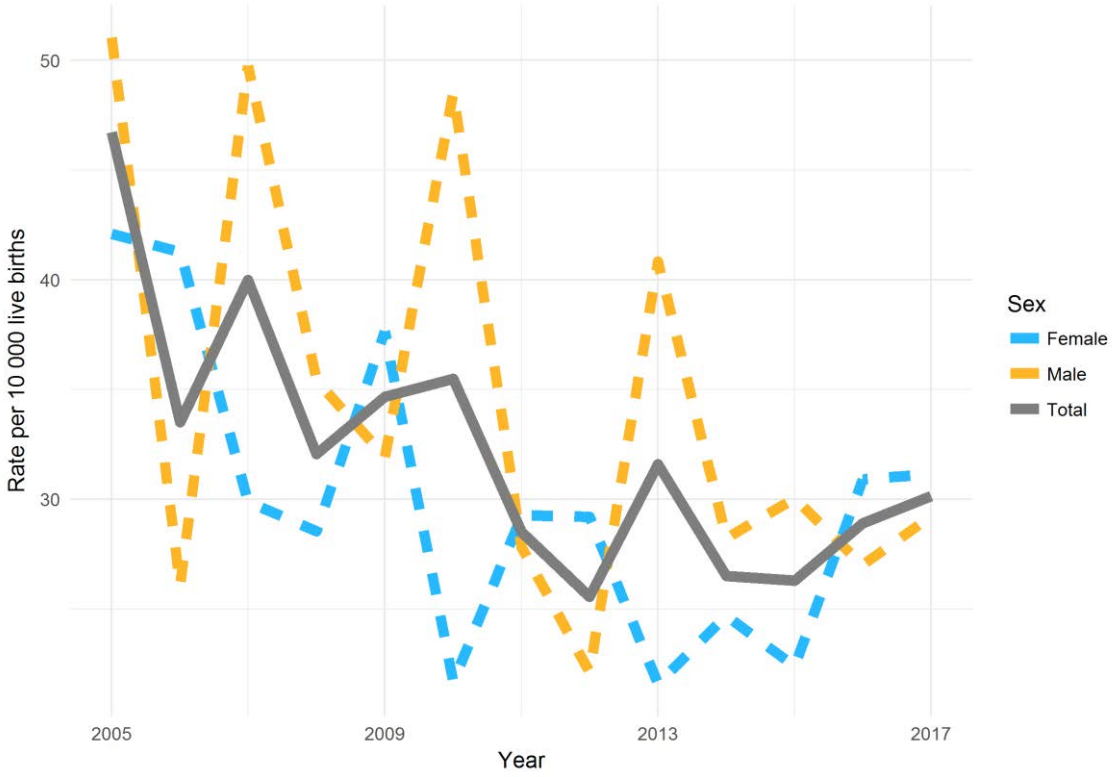

Figure 13: Death rate per 10 000 live births by year of death and sex, for children aged less than 12 months, South Australia 2005-2017

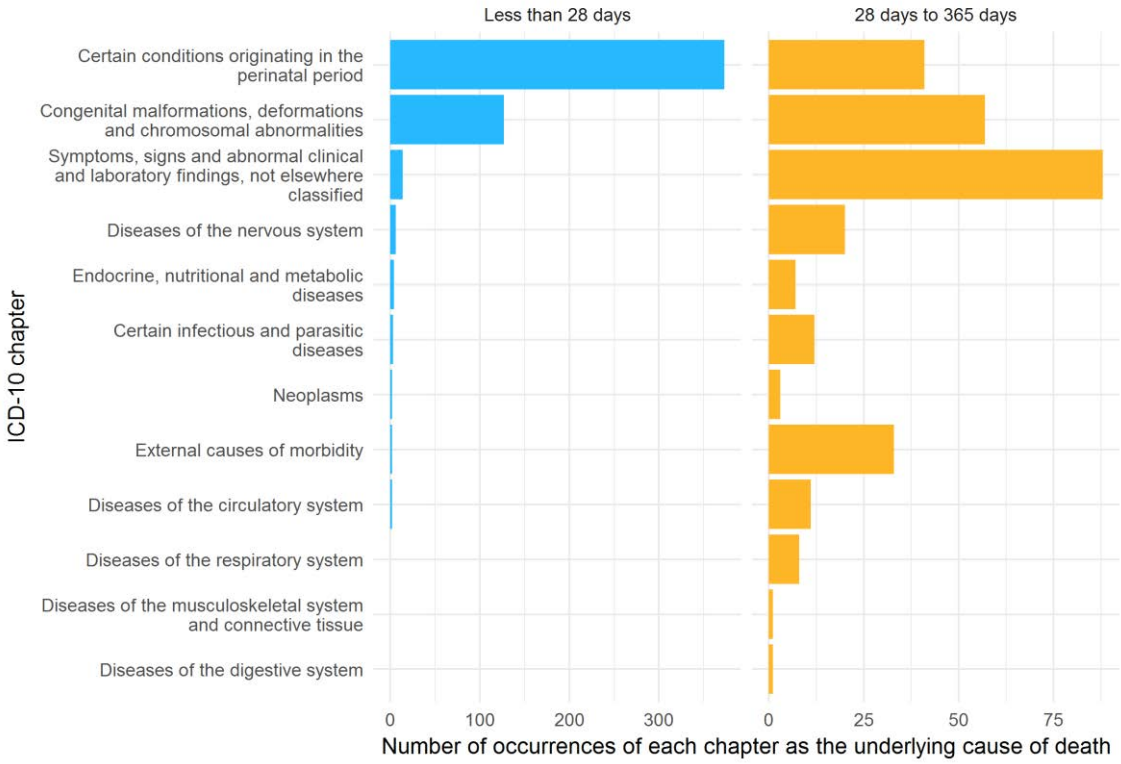

Figure 14: Number of occurrences of ICD-10 chapters, by age at death for children aged less than 12 months, South Australia 2005-2017

The conditions most often associated with the deaths of infants in their first 28 days were to do with problems occurring during pregnancy and birth. For infants over 28 days of age, the causes of death are more varied.

Figure 15 shows that the highest death rate occurs in the Far North region. However, from the perspective of service delivery, it is important to note that the highest number of deaths occur in the Northern Adelaide region[21].

[21] *The full breakdown of deaths, population and rate for each region is in Data table 15.*

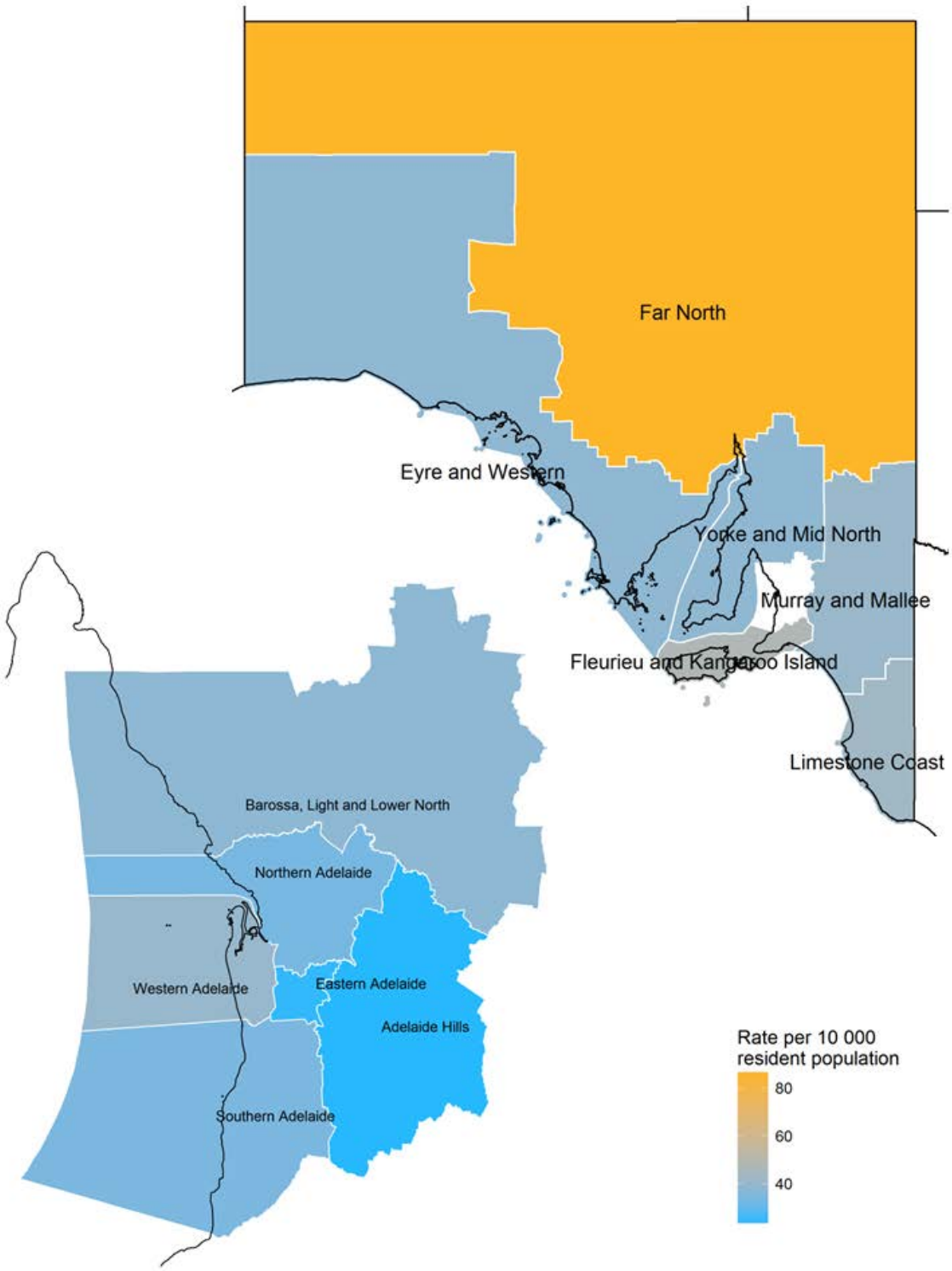

Figure 15: Death rate by region, for children aged less than 12 months who were usual residents and had a definable geographic region, South Australia 2005-2017

1.6.1. Safe sleeping of infants[22]

The South Australian Safe Infant Sleeping Standards[23] are a comprehensive set of standards for placing infants less than 12 months old to sleep. These standards were developed to help reduce the occurrence of sudden unexpected deaths of infants during sleep. Several factors occur frequently in the circumstances of these deaths. These factors are not causes of death in their own right. Rather, they increase the risk of infants dying after being placed to sleep. The Standards provide a consistent suite of messages that health professionals can use to guide the decisions families make about safe infant sleeping. The factors include:

- the infant not sleeping in an Australian standards-approved cot
- parental smoking
- not breast-feeding
- bed-sharing
- the infant not being placed on their back to sleep.

Through the careful work of South Australia police, a great deal of information about the circumstances of sudden unexpected infant deaths is recorded that can help prevent similar deaths from occurring in the future. Between 2005 and 2016 in South Australia, there were 128 cases where an infant died after being placed to sleep. In 118 of these cases at least one of the identified factors was present.

The Committee has analysed data about the factors that occurred in the circumstances of these deaths. Figure 16 shows these factors and how they co-occur. Some important intersections include:

- in more than three quarters of the cases in which a parent smoked, the infant was not in an approved bed[24] during the fatal sleep episode
- in more than half the cases in which the infant was not breast-fed, a parent also smoked.

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[22] *This chapter was originally published on the Committee's website in July 2018: http://www.cdsirc.sa.gov.au/?p=277*
[23] *https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/child+health/safe+infant+sleeping+standards*
[24] *https://www.productsafety.gov.au/standards/household-cots*

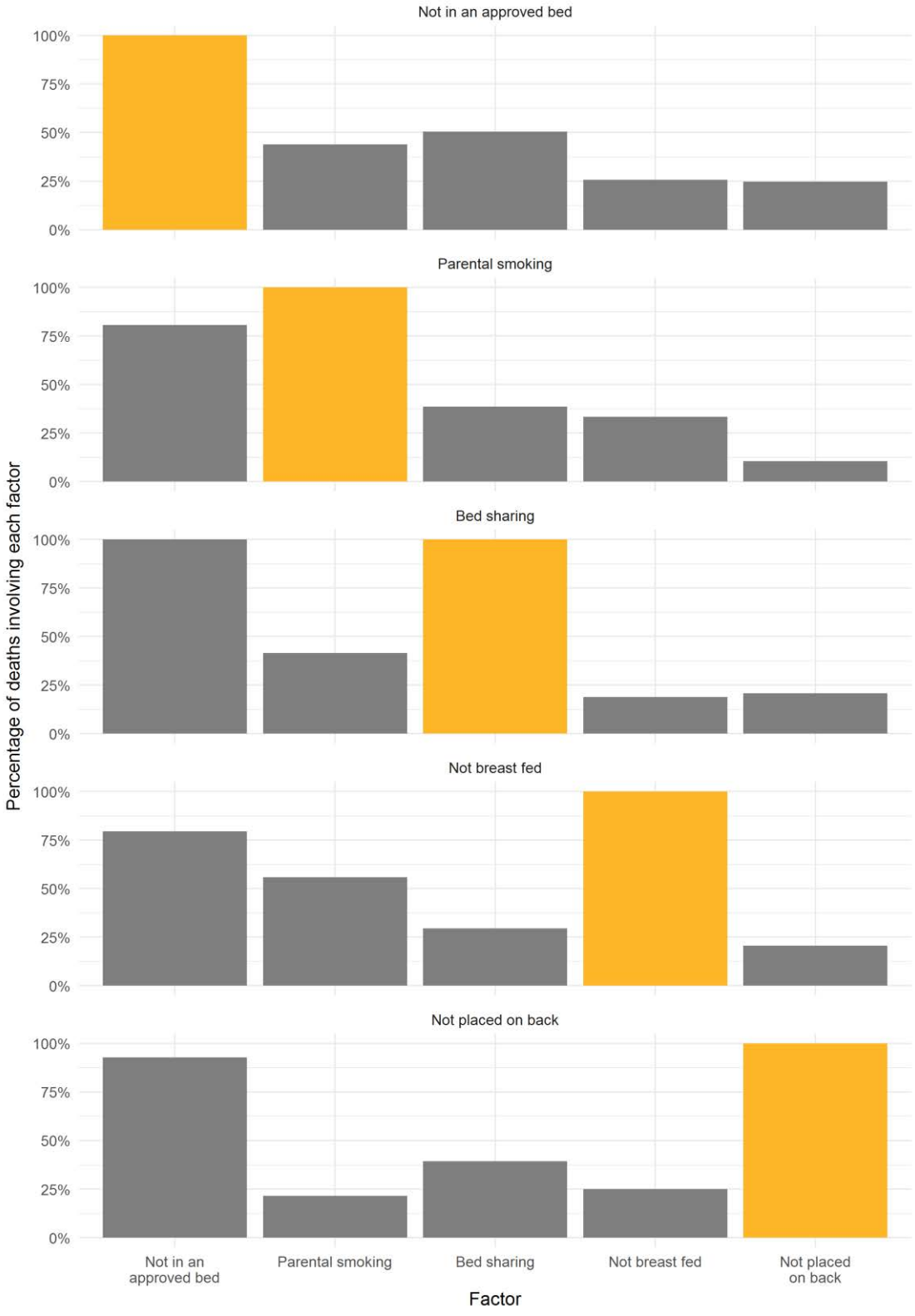

Figure 16: Percentage of deaths involving five unsafe sleeping factors, by each factor, for children aged less than 12 months whose death was sudden and unexpected and occurred after being placed to sleep, South Australia 2005-2016

These data have driven the recommendations by the Child Death and Serious Injury Review Committee in 2006[25] and 2016[26] that all families be provided with an approved bed for their infant to sleep in, along with information about safe infant sleeping. This is particularly true for families living in the most disadvantaged areas of South Australia. As shown in the Committee's April 2018 blog post[27], sudden unexpected infant deaths occur more frequently in the State's most disadvantaged areas.

The Kidsafe SA baby sling campaign

In May 2018, Kidsafe SA launched its safety campaign about baby slings and carriers[28]. The launch received national media coverage. Through social media, the baby slings safety video that was developed as part of the campaign, reached over 200 000 people. The Committee supported this campaign through the provision of information about the number and circumstances of deaths in South Australia involving baby slings, and with advice and feedback during the development of the campaign.

Mandatory safety standards for cots

In November 2016, the Committee wrote to the Australian Competition and Consumer Commission (ACCC), supporting the introduction of additional **mandatory** standards for mattress firmness testing. However, the standard for mattress firmness testing (AS/NZS 8811.1:2013 Methods of testing infant products – Sleep Surfaces – Test for firmness[29]) remains a **voluntary** standard. The current mandatory standard only requires a mattress to be sufficiently firm, but does not define the test that should be used to assess firmness.

In the absence of a mandatory standard, Kidsafe SA[30], and SIDS and Kids SA[31] advise parents to test the firmness of the mattress being used for infant sleep.

Given the association between sudden unexpected infant death and soft sleeping surfaces[32], the Committee continues to support the introduction of a mandatory standard for mattress firmness testing.

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[25] http://www.cdsirc.sa.gov.au/wp-content/uploads/2017/07/2005-06_cdsirc_annual_report.pdf
[26] http://www.cdsirc.sa.gov.au/wp-content/uploads/2017/07/2015-16_cdsirc_annual_report.pdf
[27] http://www.cdsirc.sa.gov.au/?p=240
[28] http://www.kidsafesa.com.au/babyslings/what-are-baby-slings-and-carriers-
[29] https://www.standards.org.au/standards-catalogue/sa-snz/consumer/cs-003/as-slash-nzs--8811-dot-1-2013
[30] http://www.kidsafesa.com.au/home-safety/safe-infant-sleeping/mattress-safety
[31] https://rednose.com.au/article/what-is-a-safe-mattress
[32] *Schlaud, M., Dreier, M., Debertin, A., Jachau, K., Heide, S., Giebe, B., Sperhake, J., Poets,C. and Kleemann, W. (2009). The German case–control scene investigation study on SIDS: epidemiological approach and main results.* Int J Legal Med*, 124(1), pp.19-26.*

1.7. Deaths from illness or disease

1.7.1. The number and causes of death from illness or disease

During the period 2006-17, 67.08% of child deaths in South Australia were attributed to illness or disease. The vast majority of these deaths were of infants under one year of age, and were associated with problems related to labour and delivery, or to chromosomal abnormalities.

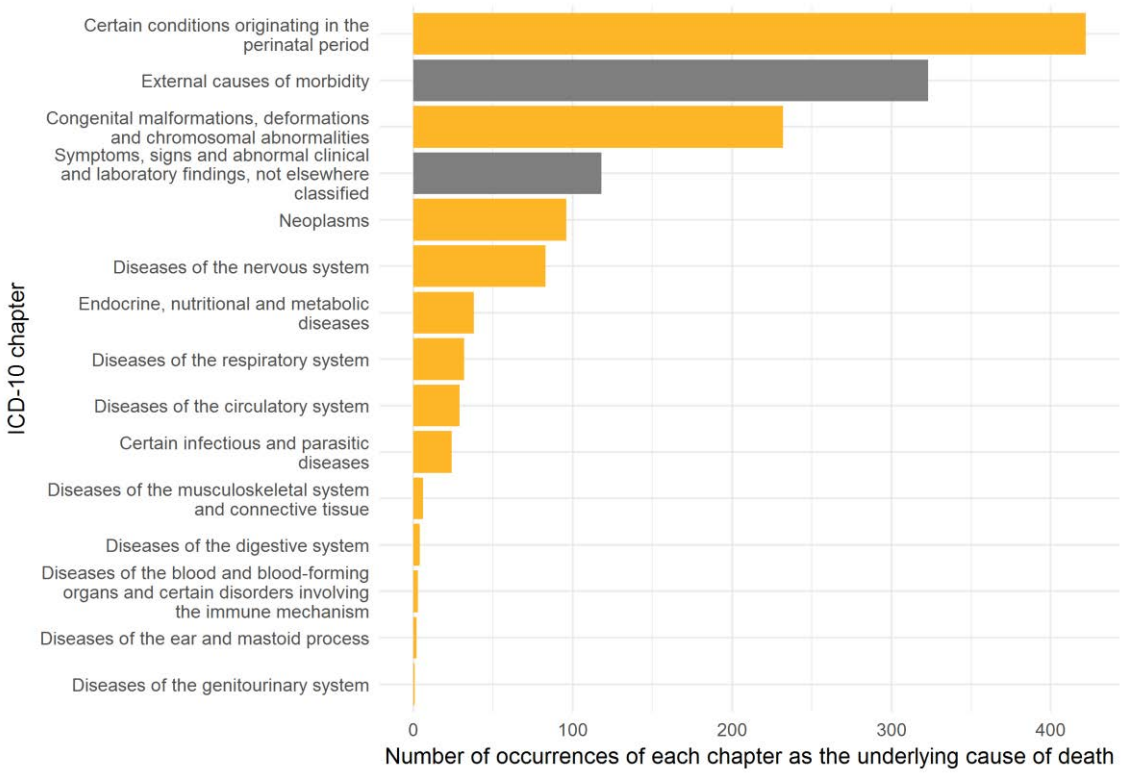

Figure 17: Number of occurrences of ICD-10 chapter, with chapters for illness or disease highlighted, for all children, South Australia 2005-2017

Figure 18 shows that the highest death rate occurred in the Far North region. However, from the perspective of service delivery, it is important to note that the highest number of deaths occurred in the Northern Adelaide region[33].

[33] *The full breakdown of deaths, population and rate for each region is in Data table 18.*

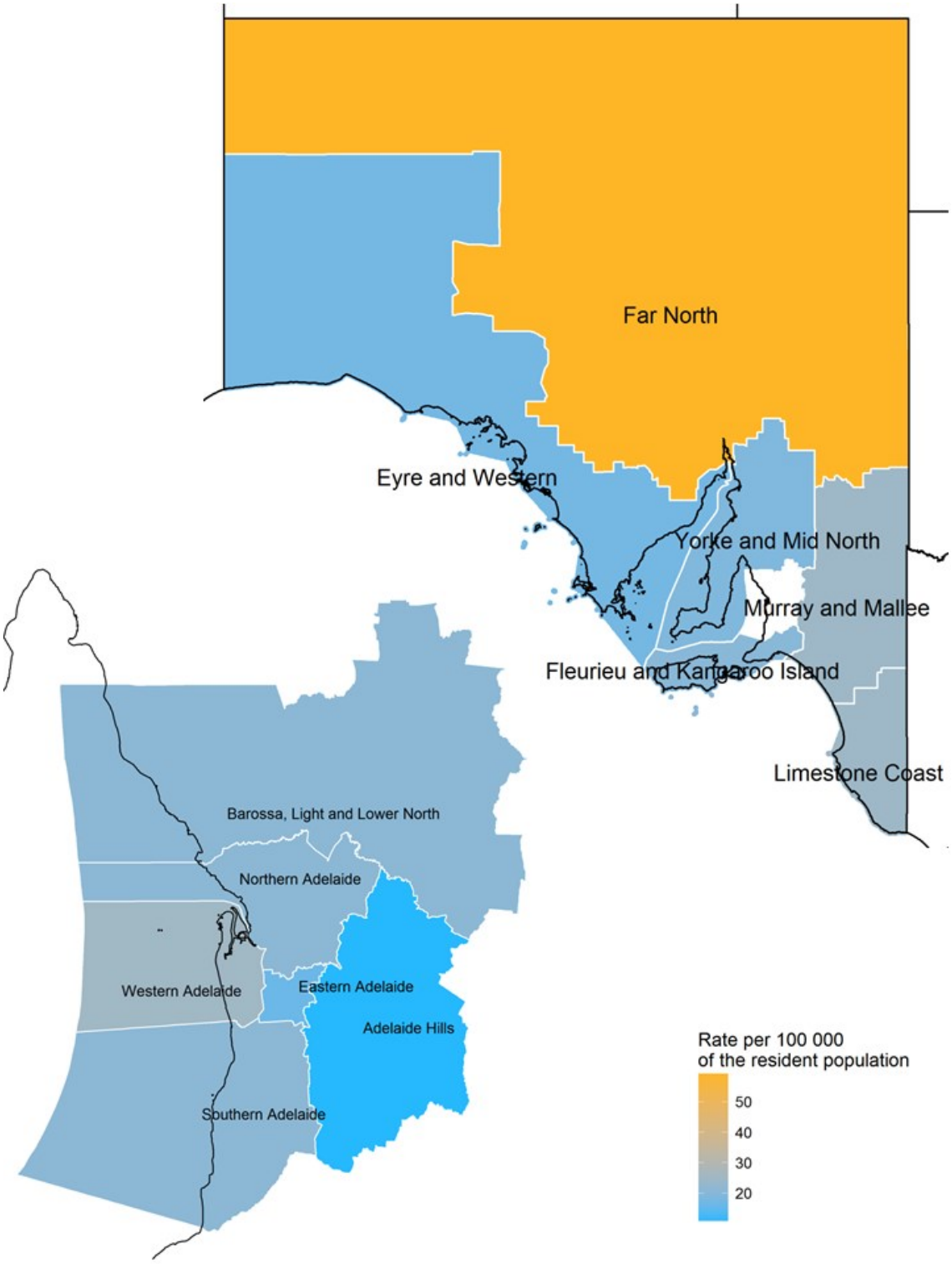

Figure 18: Death rate for illness or disease by region, for children who were usual residents and had a definable geographic region, South Australia 2005-2017

1.7.2. Review of child deaths attributed to asthma

Between 2005 and 2016, the deaths of 14 children were attributed to asthma. A review of the six deaths that occurred between 2005 and 2010 was submitted to the Minister for Education in 2012[34]. A review of eight subsequent deaths to 2016 was submitted to the Minister in 2018.

The children in this later review of eight deaths ranged in age from 19 months to 17 years. Five of these children had a history of hospital admissions for asthma, but six of the eight had not been seen by a medical practitioner in the six months prior to their deaths. There was no evidence that any of these children were under the long-term care of a paediatric respiratory specialist.

In 2017 and 2018, the Committee has raised awareness of the circumstances of the deaths of children resulting from asthma by presenting this information to SA Health staff, paediatric respiratory clinicians, asthma care nurses, staff of the Department for Education, Asthma SA, and the Child and Adolescent Health Community of Practice.

Recommendations arising from the 2018 review focused primarily on the recognition and care of children with poorly controlled and unstable asthma, as detailed in the following table.

The Committee intends to seek the support of the Minister for Health and Wellbeing to progress these recommendations with SA Health, and to discuss the ways in which the Committee will monitor implementation.

[34] *CDSIRC Annual Report 2011-12 p55-57 http://www.cdsirc.sa.gov.au/wp-content/uploads/2017/07/2011-12_cdsirc_annual_report.pdf*

Table 1: Recommendations about recognition and management of childhood asthma

Recognition of poorly controlled asthma
SA Health to undertake consumer education with families at point of service, to assist them to recognise extended periods of poorly controlled asthma in their children. Such consumer education should emphasise the importance of seeking regular review from a paediatric respiratory specialist. SA Health to undertake training of teaching staff, general practitioners and paediatricians about recognition of, and action during, extended periods of poorly controlled asthma.
Admission to hospital or presentation to a hospital emergency department as a trigger for medical review
As part of the quality management for all children discharged with an asthma-related diagnosis from a South Australian high dependency unit or paediatric intensive care unit, SA Health is to ensure that evidence is collected of medical follow-up by a paediatric respiratory specialist within two to four weeks[35]. SA Health to monitor follow-up by a lead asthma management medical practitioner (a general practitioner, paediatrician or a paediatric respiratory specialist) after a child's admission to a South Australian hospital ward, or presentation to an emergency department, with an asthma-related diagnosis. Medical review should occur within two to four weeks of admission to hospital or presentation to an emergency department[36]. SA Health to consider assertive follow-up of children from vulnerable families who were admitted to a South Australian hospital, or who presented to a South Australian emergency department with an asthma-related diagnosis.
Specialist care of children with poorly controlled or unstable asthma
SA Health to consider recommending that the care of all children with long-term, poorly controlled or unstable asthma, be managed by specialised paediatric respiratory services or their outreach. This may include telehealth services in rural settings.
Standards of emergency management of asthma in children
SA Health and the Department for Education Inter-Agency Complex Health Review Committee to meet and negotiate agreement on a common standard of emergency management of asthma in children. In July 2018, the Committee received information that this issue was being reviewed by the Department for Education and SA Health.
Assistance with the cost of ambulance attendance
The South Australian Ambulance Service (SAAS) to consider establishing free ambulance services for families that qualify for pension concessions such as exist in Victoria. The SAAS and the Department for Education (should an ambulance be called to a school) take action to make information concerning agencies that might reimburse fees for ambulance attendance on the basis of hardship available to families.

[35] *Australian Asthma Handbook. https://www.asthmahandbook.org.au/management/children/review. Accessed 15 May 2018.*
[36] *Australian Asthma Handbook. https://www.asthmahandbook.org.au/management/children/review. Accessed 15 May 2018.*

1.8. Deaths from external causes

Deaths from external causes include those deaths that the Committee has classified as being transport-related, by suicide, due to drowning, a deliberate act by another person, fire-related, accidents (falls, suffocation and asphyxiation, poisoning), neglect, and medical misadventure.

1.8.1. The number and causes of death from external causes

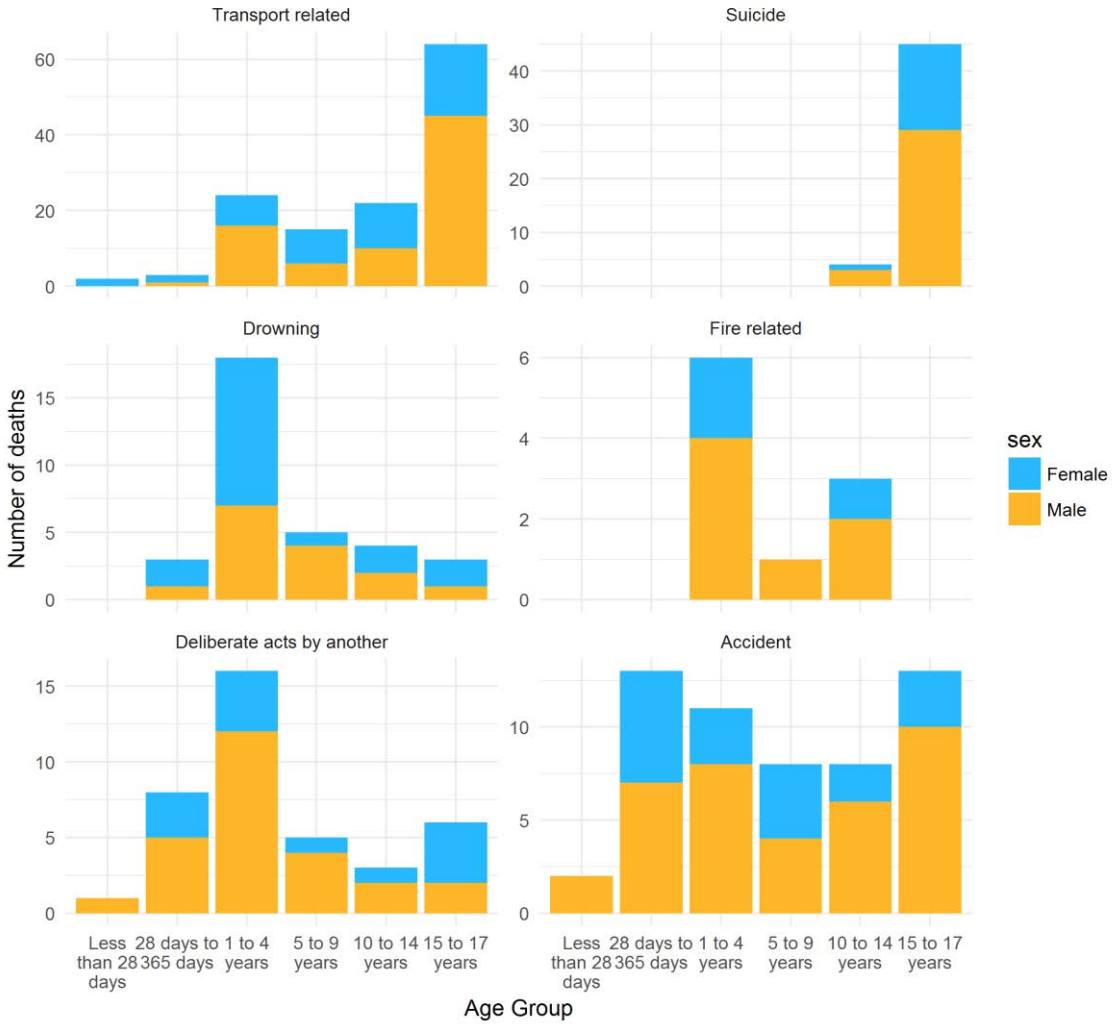

Figure 19: Number of deaths from external causes, by age group and sex for all children, South Australia 2005-2017

These figures highlight several issues about deaths from external causes:

- with few exceptions, males are more likely to die from external causes, at any age, than females
- The period between one and four years of age is a time of particular vulnerability for children. Deaths due to drowning, a deliberate act by another person, and fire-related deaths, all peak in this age group.
- transport-related deaths occur more frequently than any other external cause of death, especially for males in the 15-17 year age group.

1.8.2. Deliberate acts by another causing death

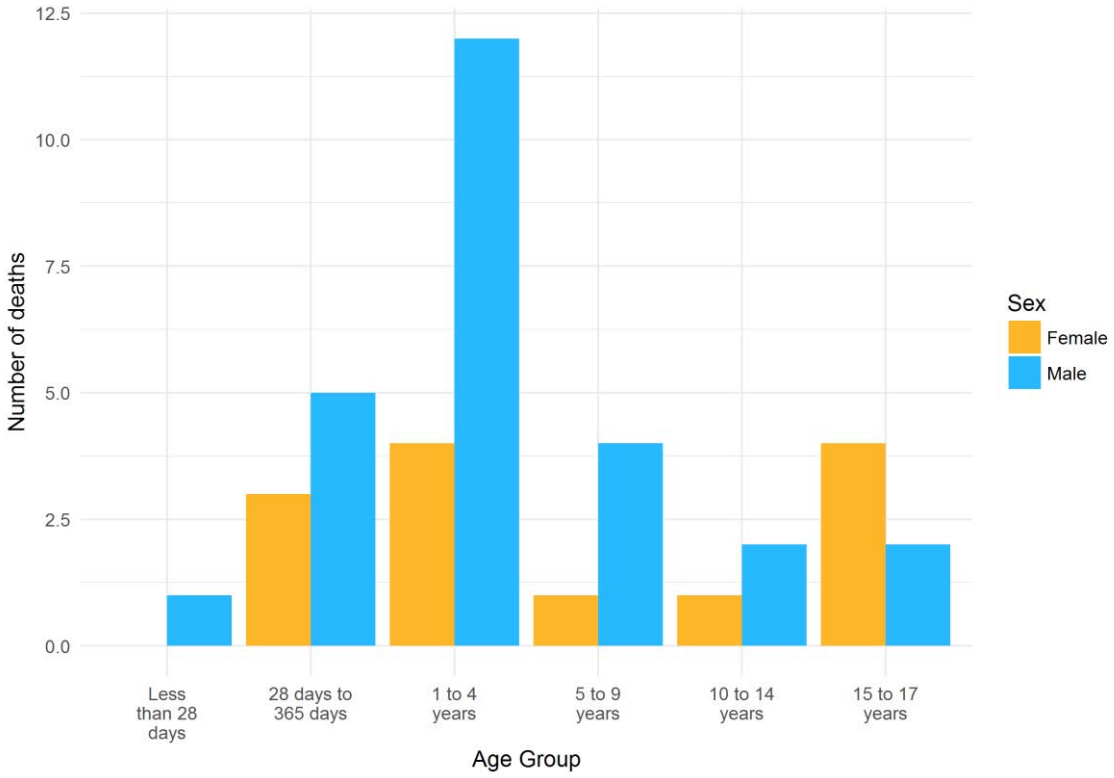

Figure 20: Number of deaths due to a deliberate act by another person, by age group and sex, South Australia 2005-2017

In all age groups, with the exception of those children aged 15-17 years, a deliberate act by another causes the death of more males than females.

1.8.3. Review of nine events of child death and serious injury involving a parent with mental illness

In March 2018, a review of the deaths of ten children and the serious injury of two others, in a total of nine events, was submitted to the Minister for Education. In each event, the death or serious injuries arose from the deliberate acts of a parent of the child(ren).

In each case, information available confirmed that the parent was, at the time of the event, experiencing mental illness. Comprising only 0.8% of the total number of child deaths between 2005 and 2016, these deaths are rare events.

The potential opportunities for prevention efforts that might reduce the risk of such deaths or serious injuries prompted this review. The review identified the key role played by practitioners who care for, and support, adult clients with mental illness, and

it was concluded that building the competence and confidence of practitioners and other workers is an important step in ensuring the best outcomes for children whose parents are affected by mental illness. We must be able to rely on adult mental health practitioners and community-based workers, infant health workers and child protection workers to:

- enquire about the needs of children in the care of parent(s) with a mental illness
- assess the parents' capacity to care for their children
- recognise any risks to child safety
- prioritise a response to inform and support the family, and to ameliorate risks.

The review also illustrated that the effect of mental illness on a parent may not be recognised by friends or family, and contact with mental health professionals may be limited or non-existent.

The Committee will seek a meeting with the Minister for Health and Wellbeing to discuss the best ways to progress the recommendations detailed in Table 2.

Table 2: Recommendations arising from the review of nine events of child death and serious injury involving a parent with mental illness

Recommendations arising from the review of nine events of child death and serious injury involving a parent with mental illness
Where needed, families be provided with comprehensive information to assist their understanding of the impact of a parent's mental illness on children.
Family-focused training be provided, as well as appropriate support and supervision, for all practitioners and community-based workers (including GPs, psychiatrists, psychologists, those working in mental health, infant health, and child protection) who come into contact with parents experiencing mental illness. Training materials are available through the National Workforce Centre for Child Mental Health (Emerging Minds). Access to child mental health workforce consultants is also available through the Centre.
The South Australian Government requires organisations to: - incorporate monitoring and evaluation of this training in their quality assurance or audit measures; and - provide evidence that training, support and supervision is maintained.
All such training explicitly recognises that the risk to children's safety of having a parent with mental illness, includes the possibility of serious injury or death.
The Committee calls on the South Australian Commissioner for Mental Health to support these recommendations.

1.8.4. Deaths attributed to suicide

Between 2005 and 2017, 49 deaths have been attributed to suicide[37]. Of this number, 32 (65.3%) were male and ten (20.4%) were Aboriginal. These 49 deaths represent 3.42% of the total number of child deaths between 2005 and 2017. Forty-five of these 49 deaths were of children aged between 15 and 17 years. Based on the Committee's system for classifying deaths, this makes suicide the third most common cause of death for children aged 15 to 17 years.

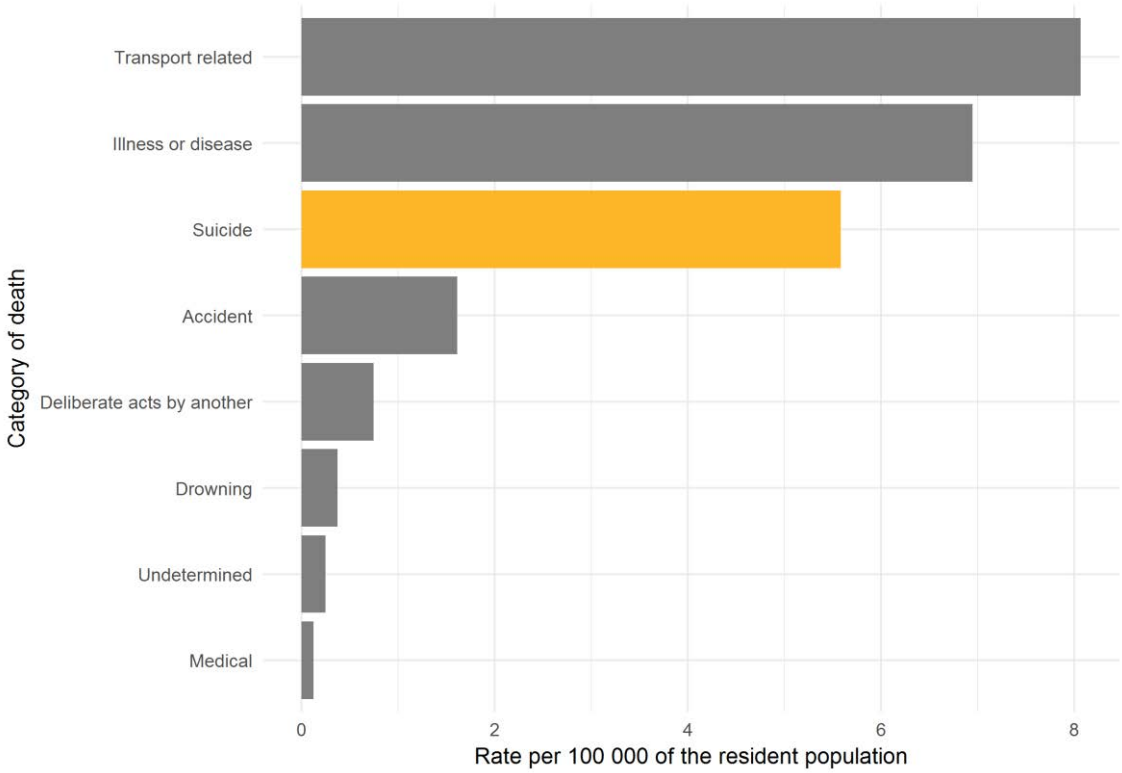

Figure 21: Death rate by category of death, with deaths by suicide highlighted, for children aged 15-17 years, South Australia 2005-2017

1.8.5. Review of deaths attributed to suicide

The Committee continues to add to its knowledge and understanding of the patterns of life circumstances and reasons why young people suicide. This knowledge informs the Committee's recommendations regarding intervention and prevention strategies. Forty-one of the forty-nine deaths (84%) attributed to suicide since 2005, have been

[37] *See Table 3 for the Committee's definition of suicide. In some cases, it has proven very hard to reach a conclusion as to whether a death should be attributed to suicide, based on the information available to the Committee. The Committee must be satisfied that the child intended to take their own life.*

reviewed using a life chart methodology[38]. Those cases not yet reviewed await a coronial finding.

Of the 41 cases reviewed, 20 (49%) have been identified as having a life chart that show the emergence of significant mental health issues in adolescence. Prior to emergence of these issues, the children were engaged with family, friends and at school. They had a supportive adult family member and/or school services, and while all had received mental health services, they may not have remained engaged with them. Over half of these children had a history of deliberate self-harm and/or previous suicide attempts.

Twelve of these 20 children were males. At the time of death, the average age of this group was 16 years and 6 months. Eighteen children lived in metropolitan or outer metropolitan areas and only two lived in disadvantaged areas of the State. There were no Aboriginal children in this subgroup.

Intervention and prevention strategies recommended to address issues identified in the lives of these children include:

- provision of youth-oriented mental health services with an emphasis on assertive outreach and follow-up, with the capacity to support the young person's family
- co-ordination between mental health services and school support services
- youth-specific services with the capacity to explore issues relating to romantic and sexual relationships.

The life charts of the second largest subgroup (13 children) showed multiple and complex family problems impacting on the children's early lives, and associated with learning and behavioural problems that extended throughout their schooling. Child protection, juvenile justice, mental health, housing and specialist educational services were involved in the lives of these children and their families, although they were often disengaged from family, friends and school at the time of their deaths.

Twelve of the 13 children were male and the average age was 16 years and 4 months. Nine of the 13 children lived in the State's most disadvantaged areas. This subgroup included three Aboriginal children.

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[38] *CDSIRC Annual Report 2013-14 p 24-25* *http://www.cdsirc.sa.gov.au/wp-content/uploads/2017/07/2013-14_cdsirc_annual_report.pdf*

Prevention and intervention efforts for these children should begin early in life and include:

- strengthening parenting capacity within families during the child's very early years
- addressing learning and behavioural problems, as they are identified in early childhood
- ensuring that ongoing problems with learning and social skills are addressed, with every effort made to keep the young person engaged in education, especially in the transition to secondary school and throughout adolescence
- promoting engagement through youth-specific programs in the community, with a focus on building resilience and restoring self-esteem
- ensuring integrated service delivery across juvenile justice, drug and alcohol services, mental health services and alternative education options.

In 2017-18, no further cases were added to the third subgroup of five children who had no history of learning or behaviour problems or of emerging mental health problems. These children had stable home lives, social supports and connections with school. Some of them had been exposed to suicide through those connections. Challenges to their romantic, sexual and/or social relationships had been experienced in the days or weeks proximal to their suicides, but they had not accessed support services. All had spoken to friends about suicide, at least in general terms, in the weeks prior to their deaths.

Intervention and prevention strategies recommended to address issues identified in the lives of these children should include:

- readily available and accessible support and information sources – through school, workplace and/or community as well as 'crisis' support, for young people during the critical hours when they appear to decide to suicide.
- population-based prevention programs that emphasise the role that friends play in helping peers who are considering suicide.

Following discussion with expert advisors undertaking research into Aboriginal suicide, the deaths of four young Aboriginal people were re-considered using a 'cultural lens' to enhance understanding of the circumstances of these deaths. One death was re-assigned to an existing subgroup however, the lack of available information about the

three remaining deaths continues to prevent further exploration of the themes that might be common to each.

The Committee welcomes the proposed appointment of a Commissioner for Aboriginal Children and Young People, and anticipates that this role will be resourced to obtain and analyse information that will lead to informed decisions about culturally appropriate intervention and prevention strategies for these children.

1.9. Monitoring causes of serious injury to children

From time to time the Committee reviews cases of serious injury.

1.9.1. Three cases of hot water scalding

Two recommendations to address the risk of children being scalded by hot tap water were made following the review of serious injuries to three children in 2015[39].

As requested, the then Minister for Education and Child Development wrote to the Australian Building Codes Board (ABCB) supporting amendments to the Plumbing Code to require temperature control for replacement hot water heaters, regardless of the age of the property. The ABCB also wrote to the Committee, at its request, and confirmed that, in November 2017, based on the information in its Decision Regulatory Impact Statement, the ABCB *'concluded that due to the inconsistent implementation of this measure around the country, there would be costs that outweighed the societal benefits for those jurisdictions that would need to transition away from like for like replacement hot water heaters'*[40].

More simply put, the ABCB had decided on the basis of its evidence, that mitigation in risk and/or the reduction in fatalities associated with hot tap water scalding did not justify the '*requested amendments to the Plumbing Code'.*

The Committee has participated in a meeting of key stakeholders and agreed to support actions aimed at reducing the likelihood of these incidents occurring in South Australia, and at a national level to provide further evidence to the ABCB for its consideration.

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[39] *CDSIRC Annual Report 2016-17 p 41 http://www.cdsirc.sa.gov.au/wp-content/uploads/2017/11/2016-17-CDSIRC-Annual-Report.pdf*

[40] *https://www.abcb.gov.au/Resources/Publications/Consultation/Application-of-temperature-control-requirements-for-heated-water*

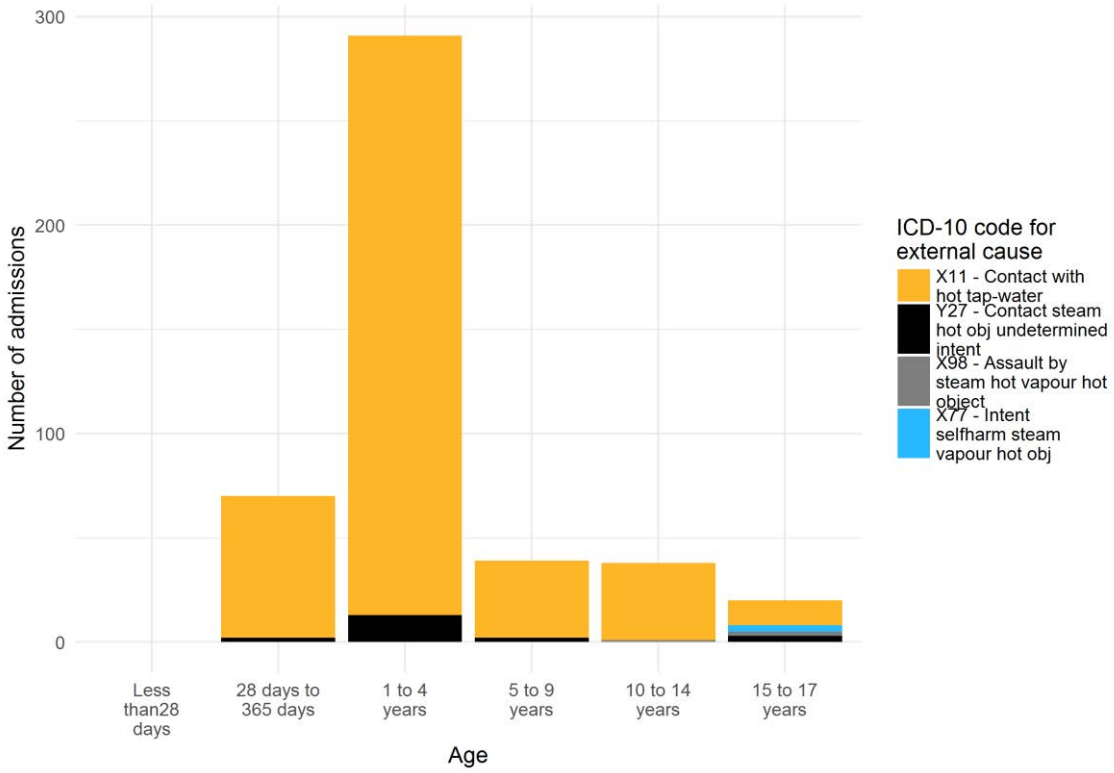

Figure 22: Number of hospital admissions that had an ICD-10 principle diagnosis or additional diagnosis in the range T20-T32 and with and external cause of X11, X77, X98 or Y27, South Australia 2005-2017

1.9.2. Self-harm and South Australian children

There are many forms of self injurious behavior and it has been reported that suicide is the 'rare end point' of such behaviour[41]. Self-harm is 40-100 times more prevalent than suicide in young people, most of whom use it as a coping strategy that 'allows them to continue to live'[42].

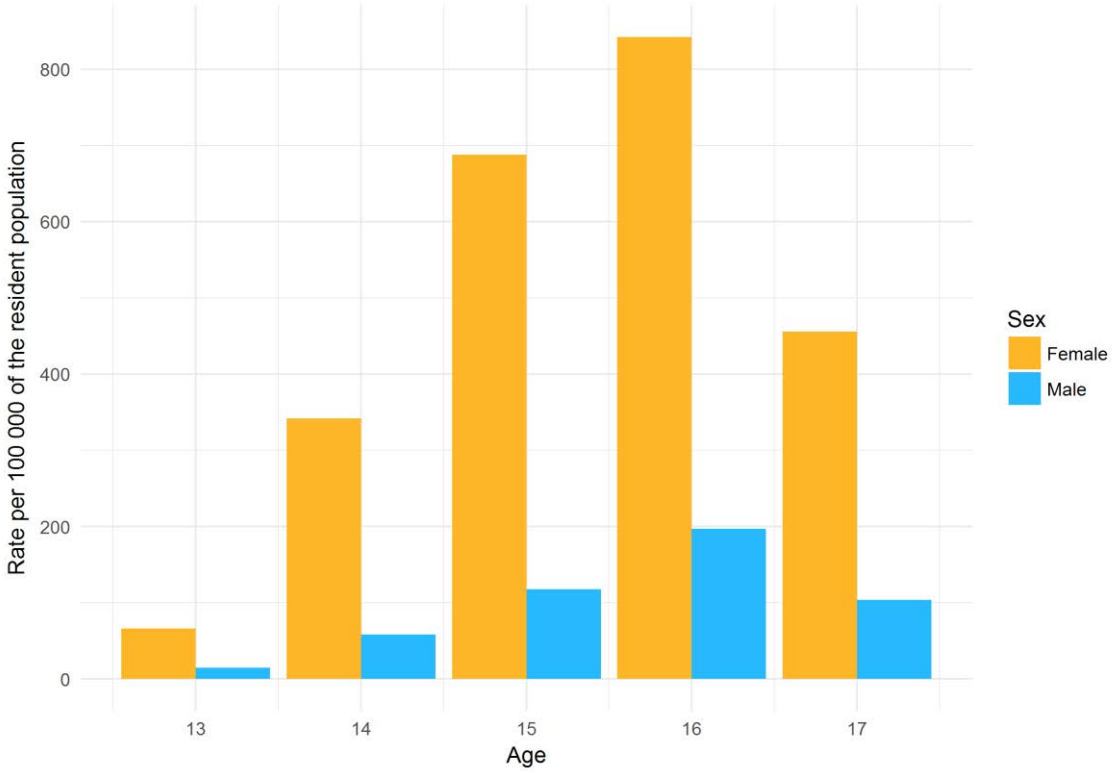

Figure 23: Rate of hospitalisation by age and sex for all hospital admissions that had an ICD-10 chapter code or external cause code between X60-X84 or Y10-Y34, South Australia 2005-2016

Self-harm that is serious enough to require hospitalisation occurs more frequently in females than in males. This analysis of self-harm hospitalisations for South Australian children undertaken by the Committee, is entirely consistent with national trends for age and sex distribution for hospitalised intentional self-harm reported by the AIHW[43].

The higher rate of hospitalisation for self-harm among females contrasts with the higher rate of death of males attributed to suicide (p 39).

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[41] *Fox, C. & Hawton, K. (2004) Deliberate self-harm in adolescence. Jessica Kingsley Publishers: London.*
[42] *Nock, M.K., Prinstein, M.J. et al. (2009) Revealing the form and function of self-injurious thoughts and behaviours: A real-time ecological assessment study among adolescents and young adults. J Abnormal Psychol. 118(4): 816-827.*
[43] *AIHW: Harrison JE & Henley G 2014. Suicide and hospitalised self-harm in Australia: trends and analysis. Injury research and statistics series no. 93. Cat. no. INJCAT 169. Canberra: AIHW. https://www.aihw.gov.au/getmedia/b70c6e73-40dd-41ce-9aa4-b72b2a3dd152/18303.pdf.aspx?inline=true*

Section Two

2. Committee Matters

S30 – Continuation of Child Death and Serious Injury Review Committee

(1) The Child Death and Serious Review Committee established under the *Children's Protection Act 1993* continues in existence.

Children and Young People (Oversight and Advocacy Bodies) Act 2016

2.1. Legislation and purpose

The Child Death and Serious Injury Review Committee continues in operation under Part 4 of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*[44]. This continuance follows on from the partial repeal of the *Children's Protection Act 1993* on 18 December 2017.

The role of the Committee is to contribute to the prevention of death or serious injury to children in South Australia.

The Committee reviews the circumstances and causes of death or serious injury to children, and makes recommendations to Government that may help prevent similar deaths or serious injuries. Recommendations suggest changes to legislation, policies, procedures or practices.

2.2. Committee matters 2017-18

The Committee met eleven times in 2017-18. In addition to attendance at these meetings, each member contributed their knowledge and expertise to regular meetings of one or more Special Interest Groups: child protection; health; disability; suicide prevention; sudden unexpected deaths in infancy; Aboriginal children, and child safety. In-depth reviews were undertaken by review teams drawn from the Committee, meeting as required to plan and complete each review.

The Committee continued its work in the following areas:

- the timely and accurate collection of information about the circumstances and causes of child deaths and serious injuries
- screening the circumstances and causes of each child death in South Australia, and identifying systemic issues to be addressed through the review process
- undertaking reviews of deaths and serious injuries to identify systemic issues, and making recommendations to the Minister for Education about systemic changes that will contribute to the prevention of similar deaths or serious injuries

[44] *The Children and Young People (Oversight and Advocacy Bodies) Act 2016 continued the existence of both the Committee and the Guardian for Children and Young People. It also established two new oversight bodies: the Commissioner for Children and Young People and the Child Development Council.*

- monitoring the progress of the implementation of recommendations, including supporting and contributing to prevention-based activities concerning child deaths and serious injuries
- contributing through its annual report and quarterly website postings, to Government and community knowledge, understanding of the causes of child deaths and serious injuries, and the efforts that should be made to prevent or reduce deaths or serious injuries
- reporting to the Minister for Education on the performance of its statutory functions
- Maintaining links with interstate and national bodies undertaking similar work.

2.3. Governance and support

From 17 May 2018, the administration of the provisions governing the Committee were given to the Minister for Education, under the *Administrative Arrangements Act 1994*. Prior to this, the provisions were administered by the Minister for Education and Child Development (from 10/11/2016) and then the Minister for Child Protection (from 22/3/2018).

In this reporting period, the Chair met with each of these Ministers.

The Committee's administrative, financial and human resource management is overseen by the Department for Education. Prior to March 2018, this oversight was the responsibility of the Department for Education and Child Development.

The Committee was supported by:

Dr Sharyn Watts	Executive Officer (1.0FTE)
Ms Rosemary Byron-Scott	Senior Project Officer (0.6FTE)
Ms Una Sibly	Senior Project Officer (0.4FTE)
Dr Owen Churches	Information Coordinator (1.0FTE)
Ms Nikki Kearney	Administration and Information Officer (1.0FTE)

2.4. The ANZCDR&PG

In June 2015, the responsibility for chairing the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG) passed to the Chair of the Committee, for a three-year term.

The Committee hosted its third and final two-day meeting of the ANZCDR&PG in April 2018. Child death review teams from all states and territories were represented at this meeting. The National Children's Commissioner and a representative from the Australian Institute of Health and Welfare also attended.

Over the course of the two days, delegates were provided with the opportunity to inform and deepen their child death review knowledge and practices. The association between child deaths and child protection, issues regarding the deaths of Aboriginal children, transport deaths, and suicide prevention were some of the issues discussed at the meeting. Each jurisdiction spoke about the current focus of their death review work and the challenges they face in undertaking that work. The National Children's Commissioner provided a summary of the national focus for children.

The Committee presented the final analysis of data provided by each jurisdiction about sudden unexpected infant deaths.

Delegates discussed draft guidelines prepared by the Committee, to help facilitate the national monitoring of child deaths. Under the auspices of the NSW Ombudsman, this work will be progressed by the NSW Child Death Review team, which will commence its three-year term as Chair of the ANZCDR&PG in June 2018.

2.5. Future directions

In 2018-19, the Committee will focus on:

- Timely and accurate collection and analysis of data about child deaths and serious injuries especially:
    - improvements to the storage of information about child deaths through enhancements to the child death database
    - improvements to the analysis of information about areas of the state where children have died
    - enhancements to linkage of child death data to other large administrative databases.

- Review of child deaths and serious injuries, especially:
    - the deaths of children who had contact with the child protection system after the commencement of implementation of child protection systems reforms associated with the Royal Commission into the Child Protection System
    - child deaths attributed to suicide, through the ongoing review of these deaths using the life chart methodology.
- Monitoring the implementation of recommendations arising from previous reviews, especially:
    - strengthening support systems for children under guardianship and for children with disability
    - the appointment of a Commissioner for Aboriginal Children and Young People
    - evidence that the child protection system is responding more effectively to issues of neglect and cumulative harm
    - the provision of safe sleeping programs and cots or portable safe sleeping devices for vulnerable families
    - product safety issues including water heater regulations, and legislation relating to quad bikes.
- Offering a contemporary and informed view about issues that impact on the safety and wellbeing of children through the review of legislation, policies, procedures and models of care, with a focus on the impact of government decision-making based on the analysis of linked administrative data sets.
- Promoting understanding of the scope and impact of child deaths through participation in work to advance national-level monitoring of child deaths and through contribution to the national meetings of the ANZCDR&PG.
- Promoting the value of the outcomes and analysis of child death reviews to key stakeholders through the quarterly release of topic-specific analyses on the Committee's website and in its annual report.

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Section Three

3. Methodology

3.1. Sources of information

3.1.1. Sources of information regarding a death

The *Children and Young People (Oversight and Advocacy Bodies) Act 2016* that articulates the role and functions of the Child Death and Serious Injury Review Committee empowers the Committee to request information about a case of child death or serious injury from any person (whether or not the person is a State authority, or an officer or employee of a State authority). Using this power the Committee receives information regarding the death of a child from a large range of sources and uses all this information in its decision-making.

Importantly, spatial analyses in this report, which include analyses of deaths across the regions of South Australia and across the levels of Socio-Economic Indexes for Areas (SEIFA) uses the postcode of the usual residence of the child who has died. However, the Committee has not been able to determine a South Australian postcode for eleven children who were thought by the Committee to be South Australian residents. Without this information, these deaths are not included in spatial analyses, but are included in all other analyses.

3.1.2. Sources of information regarding births

The Committee receives the number of live births for each year from the SA Health Maternal and Perinatal Mortality Committee.

3.1.3. Sources of information regarding populations across calendar year, single year of age, sex and cultural background

The Committee acquires the publicly available numbers of children resident across the dimensions of calendar year, single year of age, sex, cultural background and postcode from the Australian Bureau of Statistics (ABS). The five yearly census provides a count of the number of children resident in South Australia within the year of the census by single year of age, sex, cultural background and postcode. The ABS also provides an estimate of the number of children resident in South Australia for each single calendar year.

For the purpose of this Report, the population of children resident in South Australia by calendar year, single year of age, sex, cultural background and postcode is

interpolated as follows: the counts across single year of age, sex, cultural background and postcode are taken from the census, and assigned to the calendar years as three years before each census to two years after the census. The multiplier needed to get from the census to the estimate for each year is found, and is then applied to each of the 320112 cells in the matrix calendar year (13 levels), age (18 levels), sex (2 levels), cultural background (2 levels), and postcode (342 levels). Note that when re-aggregated, the adjusted count is the same as the estimate.

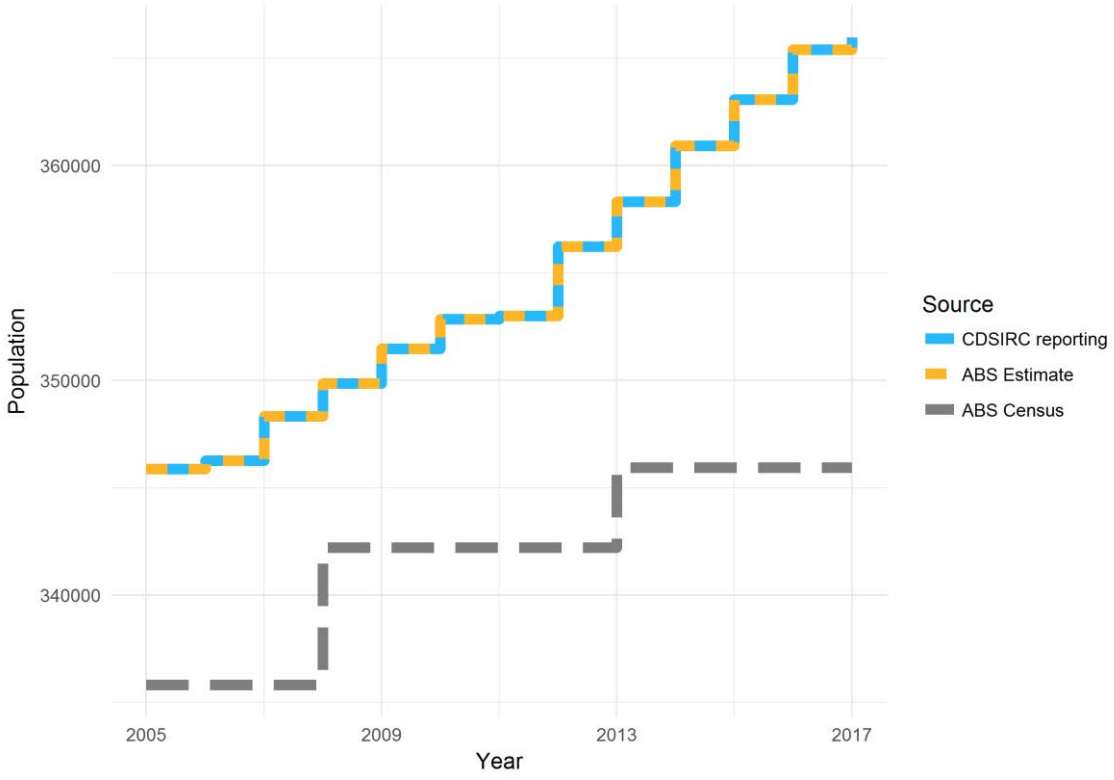

Figure 24: Populations of South Australian children aged 0 to 17 years from the original sources and the population used in this Annual Report.

3.1.4. Sources of information regarding SEIFA

For the purpose of this Report, the Committee used the measure of relative disadvantage Socio-Economic Indexes for Areas (SEIFA) decile within South Australia for each South Australian postcode acquired from the ABS census publications from 2016, and collapsed the deciles into quintiles. The postcode of the usual residence of each child who died and who was a usual resident of South Australia, was matched to the appropriate SEIFA level. On this scale, the quintile 1 includes areas with the greatest relative socio-economic disadvantage and quintile 5 includes areas with the least relative socio-economic disadvantage.

3.2. Operational definition of death used in this report

The Child Death and Serious Injury Review Committee receives information regarding the death of a child in South Australia from three government sources: the Office of Births, Deaths and Marriages, the Coroner's Office and the SA Health Maternal and Perinatal Mortality Committee. The count of deaths in this Annual Report includes all cases received from these sources with the following exceptions:

- if the Committee understands from the information gathered that the case was a termination of pregnancy
- if the Committee understands that the death occurred after the birth of an infant, prior to 20 weeks gestation.

Where there is a disagreement between the sources, the Committee reviews all the available evidence to arrive at a conclusion.

3.3. Cultural background

To differentiate grouping, the ABS uses the categories of 'Aboriginal, 'Torres Strait Islander', 'Both Aboriginal and Torres Strait Islander', 'Not stated' and 'Non-Indigenous'. For the purpose of this Report, the Committee collapses these categories into two groups, ATSI' = 'Aboriginal', 'Torres Strait Islander', 'Both Aboriginal and Torres Strait Islander' and 'Other' = 'Not stated' and 'Non-Indigenous'.

It is important to note that this determination of the cultural background of a deceased child using the multiple administrative sources available to the Committee, is a different methodology than that used by the ABS which is based on the self-report of the person completing the census form. There are good reasons to think that these are different[45].

3.4. Sudden Unexpected Deaths in Infancy

Sudden Infant Death Syndrome (SIDS) is a term used to describe the sudden and unexpected death of an infant who is less than one year of age, when the death occurs during sleep, and when the cause of death remains unexplained after a complete

[45] *A Gialamas, R Pilkington, J Berry, D Scalzi, O Gibson, A Brown, J Lynch Identification of Aboriginal children using linked administrative data: Consequences for measuring inequalities Journal of paediatrics and child health 52 (5), 534-540.*

autopsy, review of the circumstances of death, and the child's clinical history[46]. A recent development in the classification of sudden infant deaths is the use of the term Sudden Unexpected Death in Infancy (SUDI). This is an umbrella term used not only to describe cases of SIDS, but all deaths of infants aged less than 12 months that are sudden and unexpected[47].

3.5. The Committee's classification of cause of death

In many cases, the Committee has multiple sources of information available about children and is not limited to the causes of death recorded in post-mortem reports or death certificates. At the time of classifying a death, the Committee will consider all available information.

[46] *Krous, H. F., Beckwith, J. B., Byard, R. W., Rognum, T. O., Bajanowsky, T., Corey T., Gutz, E., Hanzlik, R., Keens, T. G. and Mitchell, E. A. (2004) Sudden infant death syndrome and Unclassified infant deaths: A definitional and diagnostic approach. Paediatrics, 114, 234 – 238).*

[47] *Byard R.and Krous H (2001) Sudden Infant Death Syndrome: Problems, Progress and Possibilities, Taylor & Francis.*

Table 3: Committee's cause of death classification

Cause	Committee classification
Transport–related	Transport-related deaths include deaths resulting from incidents involving a device used for, or designed to be used for, moving people or goods from one place to another. These incidents may involve pedestrians and include railway or water transport. Incidents may occur on public roads or places other than a public road.
Accidents	Accidents exclude deaths attributed to transport incidents, fires or drowning. Also referred to as deaths from unintentional injuries, these deaths most commonly include accidental: suffocation, strangulation and choking, falls and poisoning.
Suicide	The Committee's definition of suicide is: *Taking one's own life, intending to do so.* The Committee defines a death as suicide if, after a thorough review of all available evidence, it is satisfied that the young person killed him or herself intending to take their own life. Since adopting this definition, three cases previously attributed to suicide have now been reclassified as accidental deaths, resulting from misadventure.
A deliberate act by another causing death	In previous years one of the categories of death due to external causes was known as 'fatal assault.' A 'fatal assault' was defined as 'the death of a child from acts of violence perpetrated upon him or her by another person'.[48] From time to time cases were included in that category which did not really fit the definition of a fatal assault, for instance, a death caused by the deliberate administration of a drug to a child without any intention of causing the child's death. Accordingly, the Committee considered that a category known as 'a deliberate act by another causing death' better described a range of deaths, including deaths from acts of violence, where a person, by whatever means, causes a child's death by a deliberate act. It is the Committee's view that a simple definition avoids the sorts of complications that would inevitably arise if one sought to establish the intent of the person whose deliberate act results in a child's death. While a person's intent is obviously relevant to issues of criminal liability, for the Committee's categorisation of deaths this does not need to be considered. Similarly, there may be cases where the person who causes a child's death does so as a result of mental illness, leading to a Court finding of mental incompetence. Such cases are also included in this category. It will not always be possible, on the basis of the available evidence, to be certain that a child's death resulted from a deliberate act by another person. For instance a child may have serious head injuries causing death, where it is not possible to say that the injuries were deliberately inflicted, as opposed to being caused by an accidental fall. In such cases, upon consideration of all the available evidence, the Committee will decide which is the most likely cause of death.
Neglect	The Committee defines neglect as 'a death resulting from an act of omission by the child's carer(s)' including: • Failure to provide for the child's basic needs • Abandonment • Inadequate supervision, and • Refusal or delay in provision of medical care. This definition can account for both chronic neglect and single incidents of neglect, or a combination of both.[49]

[48] *Lawrence, R. (2004) Understanding fatal assault of children: a typology and explanatory theory. Children and Youth Services review, 26, 841-856.*
[49] *Lawrence, R. & Irvine, P. Redefining fatal child neglect. Child Abuse and Prevention, 21, 1-22.*

Health-system related	These deaths have been classified as such by the Committee based on written records which may not necessarily be complete. The Committee places a death in this category based on consideration of preventable aspects in the circumstances of the death and a focus on future prevention strategies rather than an investigation of the cause of death.
Sudden unexpected infant death	Sudden Unexpected Death in Infancy (SUDI) has been described as an 'umbrella' term that is used for all sudden unexpected deaths of infants younger than one year of age. The definition of Sudden Unexpected Death in Infancy (SUDI) In December 2007 the Australian and New Zealand national meeting of child death review teams and committees agreed to work towards a common reporting framework that was based on the definition of SUDI proposed by Fleming et al. (2000).[50] The agreed SUDI definition is: Infants from birth to 365 completed days of life whose deaths: Criterion 1: Were unexpected and unexplained at autopsy; Criterion 2: Occurred in the course of an acute illness that was not recognised by carers and/or by health professionals as potentially life-threatening; Criterion 3: Arose from a pre-existing condition that had not been previously recognised by health professionals; or Criterion 4: Resulted from any form of accident, trauma or poisoning.
Sudden infant death syndrome	The criteria used to determine a death attributed to SIDS continues to be the San Diego definition proposed by Krous et al. (2004, see Table 21). Death rates for SIDS are reported per 100 000 livebirths.

3.6. Disability

The definition used to determine inclusion as the death of a child with disability for children 1–17 years old is:

- the child was over one year of age at the time of death
- the child's daily activities were limited due to their disability, illness, disease or health problem; and
- the child's daily activities were adversely affected for a period of six months or more.

Where the length of time during which the child's daily activities were adversely affected was unknown, the case was not included on the Register. Cases where the child had a chronic health condition (eg asthma, epilepsy, diabetes) were only included on the Register if other disabilities were present. Some children have multiple types of disability, for example cerebral palsy and epilepsy. Multiple disabilities are recorded for each child where they are identified.

[50] *Fleming, P., Bacon, C., Blair, B. and Berry, P.J. (2000) Sudden unexpected deaths in infancy, the CESDI studies 1993-1996. London: the Stationary Office.*

Table 4: Committee's definition of disabilities

Disability	Committee definition
Neurodegenerative diseases, genetic disorders and birth defects	This category included all instances of neurodegenerative diseases, genetic disorders and birth defects, including in-born errors of metabolism where the child's health deteriorates over time. Children with many of these conditions are likely to die as a result of their disease and they require significant care as their condition progresses.
Cerebral palsy	This category included all cases of cerebral palsy, which is a term used to describe a group of non-progressive motor function disorders that arise because of damage to, or dysfunction of, the developing brain. This permanent condition can affect body movement, muscle control, muscle coordination, muscle tone, reflex, posture and balance. It may also cause visual, learning, hearing, speech and intellectual impairments, as well as epilepsy.
Epilepsy	Using the guidelines developed to identify disability, this category only included cases where the frequency and severity of the child's epilepsy adversely affected their daily activities for a period of six months or more, or the child with epilepsy had associated disability. Epilepsy is a common disorder that is characterised by recurring seizures or sudden, uncontrolled surges in the normal electrical activity in all, or part, of the brain. While the Epilepsy Centre notes that epilepsy can mostly be controlled by taking medication and restricting daily living activities, epilepsy can be associated with sudden unexpected death.
Heart and circulatory problems	This category included all cases where a condition involving the heart or blood vessels was able to be identified, regardless of whether the condition resulted from an infection or from a birth defect. Children with conditions such as complex congenital heart defects or myocardiopathy are, without life-saving surgery such as a heart transplant, at higher risk of dying as a result of their heart or circulatory problems.
Intellectual disability	This category included all cases where the available information suggested that the child had some form of intellectual disability. It was identified as a specific category because it is a developmental disorder, and people living with such disorders have significantly more difficulty than others in integrating new learning, understanding concepts and solving problems.
Autism spectrum disorder	Autism Spectrum Disorder is a lifelong developmental disability that affects, among other things, the way a child relates to his or her environment and their interactions with other people. Where information was available indicating a diagnosis of ASD had been made, a child was placed in this category.
Other types of disability	This category accommodated all of the remaining disability types in children on the Disability Register. It incorporated cases where the child had conditions such as Epstein-Barr virus, systemic lupus and community acquired pneumonia. It also included cases where the available information was too limited to confidently assign the case to a specified category.
Cancer and 'disabling medical conditions'	Several approaches to the classification of cancers and other health conditions that may adversely affect a child's life for longer than six months have been taken by the Committee. In the 2012 Special Report on the deaths of children with disability, these deaths were included in the Disability Register. In 2013, these deaths were re-classified as 'disabling medical conditions' and no longer included in the Disability Register. The Disability team considered that the issues arising from these deaths were primarily about the medical management of these conditions rather than about issues arising from the disability caused by their impact on the child. These deaths will be reported as deaths from illness or disease.

3.6.1. Infants with a disability

There is a unique set of challenges associated with identifying disability in infants. A set of criteria has been developed by the Committee to identify the deaths of infants with a disability. Deaths are excluded from consideration if the underlying cause of

death is: prematurity alone; prematurity and maternal factors; or infection; haemorrhage; digestive or respiratory problems; cancer; heart disease, including myocarditis and cardiomyopathy; or, congenital malformations of major organs such as heart, kidney and liver.

Once these cases are excluded, the remaining deaths are then reviewed by the Disability team and a decision made about inclusion in the Disability Register based on the available information. Multiple types of disability are not recorded for infants under one year of age.

3.7. Deaths of children in contact with the child protection system

To be included in this section of the Report, the child or a member of their family must have had some form of contact with DCP or its predecessors, within three years of the incident resulting in their death. The guardianship status of a child or their parent(s) is determined during this process, whether in South Australia or in another Australian state or territory.

3.8. Coding death using ICD-10

All deaths registered by the Committee are coded according to the International Classification of Diseases, Version 10 (2016) developed by the World Health Organisation. This classification system is accepted as the world standard diagnostic classification system for all general mortality and morbidity classifications[51].

3.9. In-depth review process

Deaths screened by the Committee are assigned one of the following criteria:

- Not eligible for review - a case will be considered ineligible for review under Section 37(2) of the Act if the child was not normally resident in the state at the time of death or serious injury, or the incident resulting in death or serious injury did not occur in the state.

[51] *https://www.who.int/classifications/icd/icdonlineversions/en/*

- Not for review - a case may not require in-depth review if the screening of information available at the time indicate that there are no systemic issues arising from the death. These cases are assigned a category of death, eg illness and disease, SUDI, transport, deliberate acts etc, and the details are kept on the Committee's database. They are included in the relevant annual report. They may be included in reviews in later years where features from cases aggregated over a number of years suggest that there may be systemic issues that can be addressed.
- Pending further information - in some cases the Committee requests further information before making a decision regarding in-depth review. The majority of cases awaiting further information are deaths attributed to illness and disease or health system-related adverse events. The medical screening team maintains a high level of scrutiny over the circumstances of the deaths of children from these causes, especially where children have received health services, have had complex conditions requiring a high level of care, or where there has been an interface between medical, welfare and other systems.
- Pending completion of investigations - in accordance with Section 37(4) of the Act, the Committee must not undertake a review if there is a risk that the review would compromise an ongoing criminal investigation, and cannot undertake a review of a coronial matter until that inquiry has been completed. Criminal investigations are considered to be concluded once any person involved in the death or serious injury of the child has been sentenced, or once South Australia Police have determined they have no further interest in the matter. Investigations conducted by the Coroner are considered to have ended when the Coroner has made a finding into the cause of death, or a coronial inquest has been completed.
- Awaiting assignment - in any reporting year, there are also cases ready for review but awaiting assignment to a 'review team'. The number of cases pending investigation or review gradually decreases during any year as information is obtained, cases are finalised in the criminal and coronial systems, and the Committee makes a determination about further review.

3.10. Reporting requirements

Section 39 of the Act outlines the reporting responsibilities of the Committee. It requires the Committee to report periodically to the Minister for Education, and also to provide

an annual report on the performance of its statutory functions during the preceding financial year. The Committee submits a report to the Minister for Education at the conclusion of each in-depth review. The report contains the Committee's recommendations about systemic or legislative issues that may contribute to the prevention of similar deaths or serious injuries.

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Section Four

4. Data Tables

Sex	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Female	34.46	41.54	24.78	25.84	33.32	23.29	28.52	27.68	25.26	23.37	21.53	25.33	31.47
Male	43.93	27.57	45.30	38.98	38.80	42.52	31.46	27.89	35.31	29.66	28.95	30.36	28.19
Total	39.32	34.37	35.31	32.58	36.13	33.16	30.03	27.79	30.42	26.60	25.34	27.91	29.78

Data Table 1: Death rate by year of death and sex for all children, South Australia 2005-2017

Sex	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Female	30.89	36.80	24.78	22.90	30.98	22.12	27.35	25.95	22.96	21.66	20.96	24.77	29.79
Male	39.98	26.44	41.94	36.20	37.70	42.52	29.81	26.80	32.05	28.04	26.80	29.83	27.65
Total	35.56	31.48	33.59	29.73	34.43	32.59	28.61	26.39	27.63	24.94	23.96	27.37	28.69

Data Table 2: Death rate by year of death and sex for children who were usual residents, South Australia 2005-2017

SA Government Region	Number of deaths	CDSIRC reporting population	Rate per 100 000 resident population
Adelaide Hills	40	196876.29	20.32
Barossa, Light and Lower North	61	184528.46	33.06
Eastern Adelaide	103	423219.18	24.34
Eyre and Western	53	165438.89	32.04
Far North	82	72989.22	112.35
Fleurieu and Kangaroo Island	43	126581.52	33.97
Limestone Coast	65	187478.48	34.67
Murray and Mallee	74	195555.87	37.84
Northern Adelaide	349	1117984.98	31.22
Southern Adelaide	262	895634.66	29.25
Western Adelaide	170	503154.06	33.79
Yorke and Mid North	76	181222.42	41.94

Data Table 3: Death rate by region, for children who were usual residents and had a definable geographic region, South Australia 2005-2017

Category of death	Less than 28 days	28 days to 365 days	1 to 4 years	5 to 9 years	10 to 14 years	15 to 17 years
External causes	5	29	77	34	46	132
Illness or disease	528	162	100	69	70	57
Undetermined including SIDS	13	91	12	2	1	2

Data Table 4: Number of deaths by age group and category of death for all children, South Australia 2005-2017

Usual residence	ATSI	Other
NSW	1	12
NT	25	16
Outside Australia	0	3
QLD	2	2
TAS	0	2
VIC	2	12
WA	2	5

Data Table 5: Number of deaths by state, territory or country of residence and cultural background, for children who were not usual residents of South Australia, 2005-2017

Cause of death category	Relative disadvantage SEIFA quintile within SA	Less than 28 days	28 days to 365 days	1 to 4 years	5 to 9 years	10 to 14 years	15 to 17 years
All	1	164	119	85	30	32	62
All	2	93	45	24	14	20	23
All	3	121	44	24	16	21	42
All	4	94	30	31	27	16	29
All	5	58	29	22	13	20	26
Accident	1	1	8	6	2	4	5
Accident	2	0	2	0	1	1	1
Accident	3	0	2	3	1	2	2
Accident	4	1	1	0	2	1	3
Accident	5	0	0	2	1	0	2
Drowning	1	0	1	10	0	2	0
Drowning	2	0	0	2	2	0	0
Drowning	3	0	1	1	1	0	1
Drowning	4	0	0	4	1	1	1
Drowning	5	0	1	1	0	1	0
Deliberate acts by another	1	0	0	6	1	1	1
Deliberate acts by another	2	0	4	4	2	0	3
Deliberate acts by another	3	1	3	1	0	0	0
Deliberate acts by another	4	0	1	2	2	0	0
Deliberate acts by another	5	0	0	2	0	1	2
Fire related	1	0	0	4	0	0	0
Fire related	2	0	0	0	0	0	0
Fire related	3	0	0	0	0	0	0
Fire related	4	0	0	2	1	2	0
Fire related	5	0	0	0	0	1	0
Health system related	1	1	0	1	2	1	0
Health system related	2	1	1	1	0	0	0
Health system related	3	1	0	0	0	0	0
Health system related	4	0	1	2	0	0	0
Health system related	5	0	0	0	0	0	0

Cause of death category	Relative disadvantage SEIFA quintile within SA	Less than 28 days	28 days to 365 days	1 to 4 years	5 to 9 years	10 to 14 years	15 to 17 years
Illness or disease	1	157	58	42	19	16	21
Illness or disease	2	91	25	14	9	13	9
Illness or disease	3	116	27	12	13	15	15
Illness or disease	4	90	17	12	14	7	4
Illness or disease	5	55	19	14	11	13	5
Neglect	1	0	1	1	0	1	0
Neglect	2	0	0	0	0	0	0
Neglect	3	0	0	0	0	0	0
Neglect	4	0	0	0	0	1	0
Neglect	5	0	0	1	0	0	0
SIDS	1	0	9	0	0	0	0
SIDS	2	0	5	0	0	0	0
SIDS	3	0	2	0	0	0	0
SIDS	4	0	2	0	0	0	0
SIDS	5	0	1	0	0	0	0
Suicide	1	0	0	0	0	1	9
Suicide	2	0	0	0	0	2	3
Suicide	3	0	0	0	0	0	12
Suicide	4	0	0	0	0	1	8
Suicide	5	0	0	0	0	0	9
Transport related	1	1	1	9	4	6	26
Transport related	2	0	0	2	0	3	7
Transport related	3	0	0	6	1	4	11
Transport related	4	1	1	6	7	3	12
Transport related	5	0	1	1	1	4	8
Undetermined	1	4	41	6	2	0	0
Undetermined	2	1	8	1	0	1	0
Undetermined	3	3	9	1	0	0	1
Undetermined	4	2	7	3	0	0	1
Undetermined	5	3	7	1	0	0	0

Data Table 6: Number of deaths by age group and relative advantage and disadvantage SEIFA quintile, for children who had a definable SEIFA level in South Australia, 2005-2017

Contact with child protection services	Category of death	Less than 28 days	28 days to 365 days	1 to 4 years	5 to 9 years	10 to 14 years	15 to 17 years
No family contact with child protection in three years before death	External causes	2	20	45	22	21	85
No family contact with child protection in three years before death	Illness or disease	449	125	72	47	52	44
No family contact with child protection in three years before death	Undetermined including SIDS	7	50	6	1	0	1
Family contact with child protection in three years before death	External causes	3	9	32	12	25	47
Family contact with child protection in three years before death	Illness or disease	79	37	28	22	18	13
Family contact with child protection in three years before death	Undetermined including SIDS	6	41	6	1	1	1

Data Table 7: Number of deaths by age group, category of death and child protection contact status for all children, South Australia 2005-2017

Family contact with child protection in the three years before the death	Factor	Number of deaths	Total number of deaths for this level of child protection contact	Percent of deaths within each level of child protection contact for which each risk was present
Yes	Not placed on back	9	60	15.00
Yes	Not breast fed	22	60	36.67
Yes	Not in an approved bed	48	60	80.00
Yes	Bed sharing	29	60	48.33
Yes	Parental smoking	36	60	60.00
No	Not placed on back	19	58	32.76
No	Not breast fed	12	58	20.69
No	Not in an approved bed	57	58	98.28
No	Bed sharing	24	58	41.38
No	Parental smoking	21	58	36.21

Data Table 8: Percentage of deaths involving five unsafe sleeping factors, by each factor and child protection contact status, for children aged less than 12 months whose death was sudden and unexpected and occurred after being placed to sleep, South Australia 2005-2016

Cultural Background	Category of death	Less than 28 days	28 days to 365 days	1 to 4 years	5 to 9 years	10 to 14 years	15 to 17 years
ATSI	External causes	0	4	8	6	8	20
ATSI	Illness or disease	51	23	10	4	10	7
ATSI	Undetermined including SIDS	3	15	1	0	0	0
Other	External causes	5	25	69	28	38	112
Other	Illness or disease	477	139	90	65	60	50
Other	Undetermined including SIDS	10	76	11	2	1	2

Data Table 9: Number of deaths by category of death and cultural background for all children, South Australia 2005-2017

Cultural Background	Category of death	Number of deaths	CDSIRC reporting population	Rate
ATSI	External causes	46	131170.5	35.07
ATSI	Illness or disease	105	131170.5	80.05
ATSI	Undetermined including SIDS	19	131170.5	14.48
Other	External causes	277	4486372.5	6.17
Other	Illness or disease	881	4486372.5	19.64
Other	Undetermined including SIDS	102	4486372.5	2.27

Data Table 10: Death rate, by category of death and cultural background for all children, South Australia 2005-2017

Disability status	Chapter	Code Range	Description	Number of occurrences of each chapter as the underlying cause of death
Had disability	1	A00-B99	Certain infectious and parasitic diseases	3
Had disability	2	C00-D49	Neoplasms	0
Had disability	3	D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	1
Had disability	4	E00-E89	Endocrine, nutritional and metabolic diseases	26
Had disability	6	G00-G99	Diseases of the nervous system	71
Had disability	8	H60-H95	Diseases of the ear and mastoid process	1
Had disability	9	I00-I99	Diseases of the circulatory system	6
Had disability	10	J00-J99	Diseases of the respiratory system	2
Had disability	11	K00-K95	Diseases of the digestive system	0
Had disability	13	M00-M99	Diseases of the musculoskeletal system and connective tissue	4
Had disability	14	N00-N99	Diseases of the genitourinary system	0
Had disability	16	P00-P96	Certain conditions originating in the perinatal period	30
Had disability	17	Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities	141
Had disability	18	R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	3
Had disability	20	V00-Y99	External causes of morbidity	19
No known disability	1	A00-B99	Certain infectious and parasitic diseases	21
No known disability	2	C00-D49	Neoplasms	96
No known disability	3	D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	2
No known disability	4	E00-E89	Endocrine, nutritional and metabolic diseases	12
No known disability	6	G00-G99	Diseases of the nervous system	12
No known disability	8	H60-H95	Diseases of the ear and mastoid process	1
No known disability	9	I00-I99	Diseases of the circulatory system	23
No known disability	10	J00-J99	Diseases of the respiratory system	30
No known disability	11	K00-K95	Diseases of the digestive system	4
No known disability	13	M00-M99	Diseases of the musculoskeletal system and connective tissue	2
No known disability	14	N00-N99	Diseases of the genitourinary system	1
No known disability	16	P00-P96	Certain conditions originating in the perinatal period	391
No known disability	17	Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities	91
No known disability	18	R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	115
No known disability	20	V00-Y99	External causes of morbidity	303

Data Table 11: Number of occurrences of ICD-10 underlying cause of death, by disability status, for all children, South Australia, 2005-2017

Autism	Cerebral palsy	Epilepsy	Genetic, neurodevelopmental and congenital abnormalities	Heart and circulatory abnormalities	Intellectual disability	Other specified disability
8	44	47	91	16	15	18

Data Table 12: Number of occurrences of disability types, by number of occurrences of each combination of disability types, for children with a disability status aged 1-17 years, South Australia 2005-2017

Sex	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Female	42.09	41.28	29.90	28.56	37.65	21.66	29.26	29.19	21.58	24.70	22.37	30.91	31.16
Male	51.04	26.07	49.75	35.42	31.92	48.52	27.80	22.13	40.83	28.23	30.04	27.01	29.21
Total	46.72	33.51	40.00	32.05	34.68	35.50	28.51	25.55	31.59	26.51	26.30	28.90	30.15

Data Table 13: Death rate per 10 000 live births by year of death and sex, for children aged less than 12 months, South Australia 2005-2017

Age group	Chapter	Code Range	Description	Number of occurrences of each chapter as the underlying cause of death
Less than 28 days	1	A00-B99	Certain infectious and parasitic diseases	3
Less than 28 days	10	J00-J99	Diseases of the respiratory system	0
Less than 28 days	11	K00-K95	Diseases of the digestive system	0
Less than 28 days	13	M00-M99	Diseases of the musculoskeletal system and connective tissue	0
Less than 28 days	16	P00-P96	Certain conditions originating in the perinatal period	373
Less than 28 days	17	Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities	127
Less than 28 days	18	R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	14
Less than 28 days	2	C00-D49	Neoplasms	2
Less than 28 days	20	V00-Y99	External causes of morbidity	2
Less than 28 days	4	E00-E89	Endocrine, nutritional and metabolic diseases	4
Less than 28 days	6	G00-G99	Diseases of the nervous system	6
Less than 28 days	9	I00-I99	Diseases of the circulatory system	2
28 days to 365 days	1	A00-B99	Certain infectious and parasitic diseases	12
28 days to 365 days	10	J00-J99	Diseases of the respiratory system	8
28 days to 365 days	11	K00-K95	Diseases of the digestive system	1
28 days to 365 days	13	M00-M99	Diseases of the musculoskeletal system and connective tissue	1
28 days to 365 days	16	P00-P96	Certain conditions originating in the perinatal period	41
28 days to 365 days	17	Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities	57
28 days to 365 days	18	R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	88
28 days to 365 days	2	C00-D49	Neoplasms	3
28 days to 365 days	20	V00-Y99	External causes of morbidity	33
28 days to 365 days	4	E00-E89	Endocrine, nutritional and metabolic diseases	7
28 days to 365 days	6	G00-G99	Diseases of the nervous system	20
28 days to 365 days	9	I00-I99	Diseases of the circulatory system	11

Data Table 14: Number of occurrences of ICD-10 chapters, by age at death for children aged less than 12 months, South Australia 2005-2017

SA Government Region	Number of deaths	CDSIRC reporting population	Rate per 10 000 resident population
Adelaide Hills	21	8861.83	23.70
Barossa, Light and Lower North	31	8297.29	37.36
Eastern Adelaide	52	20920.56	24.86
Eyre and Western	31	8198.11	37.81
Far North	45	4113.83	109.39
Fleurieu and Kangaroo Island	26	5483.39	47.42
Limestone Coast	39	9193.11	42.42
Murray and Mallee	37	9148.05	40.45
Northern Adelaide	206	62810.90	32.80
Southern Adelaide	159	47577.19	33.42
Western Adelaide	113	28328.79	39.89
Yorke and Mid North	31	8161.45	37.98

Data Table 15: Death rate by region, for children aged less than 12 months who were usual residents and had a definable geographic region, South Australia 2005-2017

Factor	Not in an approved bed	Parental smoking	Bed sharing	Not breast fed	Not placed on back
Not in an approved bed	100.00	80.70	100.00	79.41	92.86
Parental smoking	43.81	100.00	41.51	55.88	21.43
Bed sharing	50.48	38.60	100.00	29.41	39.29
Not breast fed	25.71	33.33	18.87	100.00	25.00
Not placed on back	24.76	10.53	20.75	20.59	100.00

Data Table 16: Percentage of deaths involving five unsafe sleeping factors, by each factor, for children aged less than 12 months whose death was sudden and unexpected and occurred after being placed to sleep, South Australia 2005-2016

Chapter	Code Range	Description	Number of occurrences of each chapter as the underlying cause of death	Illness or disease?
1	A00-B99	Certain infectious and parasitic diseases	24	Yes
2	C00-D49	Neoplasms	96	Yes
3	D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	3	Yes
4	E00-E89	Endocrine, nutritional and metabolic diseases	38	Yes
6	G00-G99	Diseases of the nervous system	83	Yes
8	H60-H95	Diseases of the ear and mastoid process	2	Yes
9	I00-I99	Diseases of the circulatory system	29	Yes
10	J00-J99	Diseases of the respiratory system	32	Yes
11	K00-K95	Diseases of the digestive system	4	Yes
13	M00-M99	Diseases of the musculoskeletal system and connective tissue	6	Yes
14	N00-N99	Diseases of the genitourinary system	1	Yes
16	P00-P96	Certain conditions originating in the perinatal period	422	Yes
17	Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities	232	Yes
18	R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	118	No
20	V00-Y99	External causes of morbidity	323	No

Data Table 17: Number of occurrences of ICD-10 chapter, with chapters for illness or disease highlighted, for all children, South Australia 2005-2017

SA Government Region	Number of deaths	CDSIRC reporting population	Rate per 100 000 of the resident population
Adelaide Hills	22	196876.29	11.17
Barossa, Light and Lower North	39	184528.46	21.13
Eastern Adelaide	69	423219.18	16.30
Eyre and Western	29	165438.89	17.53
Far North	55	72989.22	75.35
Fleurieu and Kangaroo Island	26	126581.52	20.54
Limestone Coast	46	187478.48	24.54
Murray and Mallee	48	195555.87	24.55
Northern Adelaide	236	1117984.98	21.11
Southern Adelaide	190	895634.66	21.21
Western Adelaide	127	503154.06	25.24
Yorke and Mid North	35	181222.42	19.31

Data Table 18: Death rate for illness or disease by region, for children who were usual residents and had a definable geographic region, South Australia 2005-2017

Sex	Cause of death category	Less than 28 days	28 days to 365 days	1 to 4 years	5 to 9 years	10 to 14 years	15 to 17 years
Female	Transport related	2	2	8	9	12	19
Female	Suicide	0	0	0	0	1	16
Female	Drowning	0	2	11	1	2	2
Female	Fire related	0	0	2	0	1	0
Female	Deliberate acts by another	0	3	4	1	1	4
Female	Accident	0	6	3	4	2	3
Male	Transport related	0	1	16	6	10	46
Male	Suicide	0	0	0	0	3	29
Male	Drowning	0	1	7	4	2	1
Male	Fire related	0	0	4	1	2	0
Male	Deliberate acts by another	1	5	12	4	2	2
Male	Accident	2	7	8	4	6	10

Data Table 19: Number of deaths from external causes, by age group and sex for all children, South Australia 2005-2017

Sex	Less than 28 days	28 days to 365 days	1 to 4 years	5 to 9 years	10 to 14 years	15 to 17 years
Female	0	3	4	1	1	4
Male	1	5	12	4	2	2

Data Table 20: Number of deaths due to a deliberate act by another person, by age group and sex, South Australia 2005-2017

Category of death	Number of deaths	CDSIRC reporting population	Rate per 100,000 of the resident population
Accident	13	805714.5	1.61
Drowning	3	805714.5	0.37
Deliberate acts by another	6	805714.5	0.74
Medical	1	805714.5	0.12
Illness or disease	56	805714.5	6.95
Suicide	45	805714.5	5.59
Transport related	65	805714.5	8.07
Undetermined	2	805714.5	0.25

Data Table 21: Death rate by category of death, with deaths by suicide highlighted, for children aged 15-17 years, South Australia 2005-2017

ICD-10 code for external cause	Less than28 days	28 days to 365 days	1 to 4 years	5 to 9 years	10 to 14 years	15 to 17 years
X11 - Contact with hot tap-water	0	68	278	37	37	12
X77 - Intent selfharm steam vapour hot obj	0	0	0	0	0	3
X98 - Assault by steam hot vapour hot object	0	0	0	0	1	2
Y27 - Contact steam hot obj undetermined intent	0	2	13	2	0	3

Data Table 22: Number of hospital admissions that had an ICD-10 principle diagnosis or additional diagnosis in the range T20-T32 and with and external cause of X11, X77, X98 or Y27, South Australia 2005-2017

Sex	Age	Number of admissions	CDSIRC reporting population	Rate per 100 000 of the resident population
Female	13	77	115943.4	66.41
Female	14	403	117859.7	341.93
Female	15	817	118833.7	687.52
Female	16	1014	120437.2	841.93
Female	17	552	121190.7	455.48
Male	13	18	121844.9	14.77
Male	14	72	123699.9	58.21
Male	15	148	125633.1	117.80
Male	16	255	129217.6	197.34
Male	17	133	128475.7	103.52

Data Table 23: Rate of hospitalisation by age and sex for all hospital admissions that had an ICD-10 chapter code or external cause code between X60-X84 or Y10-Y34, South Australia 2005-2016

Source	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
CDSIRC reporting	345883	346257	348320	349864	351475	352848	353001	356231	358311	360913	363074	365401	365965
ABS Estimate	345883	346257	348320	349864	351475	352848	353001	356231	358311	360913	363074	365401	365965
ABS Census	335820	335820	335820	342210	342210	342210	342210	342210	345928	345928	345928	345928	345928

Data Table 24: Populations of South Australian children aged 0 to 17 years from the original sources and the population used in this Annual Report